Brotherhood of St Laurence
Working for an Australia free of poverty

Submission to the Royal Commission into Victoria's Mental Health System

Brotherhood of St Laurence

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Brotherhood of St Laurence
67 Brunswick Street
Fitzroy Vic. 3065

ABN 24 603 467 024

Ph. (03) 9483 1183

www.bsl.org.au

For further information or to discuss this submission, please contact:

Julie Connolly
Deputy Director, Research and Policy Centre
Brotherhood of St Laurence
Email: Julie.connolly@bsl.org.au
Ph. 0402 161 887

Summary

The Opportunity

The transformation of Victoria's mental health system is long overdue. The Royal Commission provides an unparalleled opportunity not only to increase investment in mental health treatment and services, but to drive systems-level change across Government to improve outcomes for all Victorians.

Getting the framework right

Addressing systemic change requires conceptual clarity and theoretical cogency. The Brotherhood of St Laurence (BSL) recommends that the Commission give consideration to:

- **An expansive and inclusive definition of mental wellbeing** that reflects the experience of Australia's first peoples and the broader multicultural community of which we are a part
- **A deep understanding of poverty and other social determinants** on the incidence, prevalence and trajectory of mental illness
- **A life-course approach**, with which to extend approaches to promotion, prevention and early intervention
- **The inclusion of a capabilities approach,** to complement the recovery model in mental health treatment and services.

Outcomes and Strategies

The BSL urges the Commission to focus on three principal outcomes to reduce the prevalence mental illness and advance the human rights of those who are affected by it:

1. All Victorians achieve greater wellbeing across the life-course
2. Increased social inclusion and economic security for people who experience mental ill health, alongside improved access to treatment
3. An accessible and culturally relevant system of support that balances clinical and community interventions to build the capabilities of people experiencing mental illness.

Drawing on our extensive research and direct service-delivery, we have identified specific strategies that could support progress towards each of these outcomes, summarised on the following page.

A partnership approach

Transformation is challenging, neither the clinical sector nor the specialised community mental health sector can achieve change without whole of government and whole of community support. The BSL hopes to contribute to this change and looks forward to working with the Victorian Government to realise the Royal Commission's ambitions and recommendations. The BSL would like to endorse the specific recommendations for reform made by the Victorian Council of Social Services, Mental Health Victoria and the Council for Homeless Persons. We acknowledge the courage of those people deeply affected by mental illness with compassion and hope.

Strategies to achieve greater wellbeing across the life-course

PROMOTION	Increased support for population-wide mental health promotion structured with reference to risk and protective factors at different stages in the life-course
GOVERNMENT SERVICES	Embedding evidence-based practices that support improved wellbeing outcomes across all forms of Victorian government service provision, not just specialised mental health services
COMMUNITY SUPPORT	Increased investment in community-based programs and initiatives that address the social determinants of mental health and wellbeing
INDUSTRY ENGAGEMENT	Greater support for employers to develop and implement wellbeing policies for staff, clients and consumers

Strategies to increase social inclusion and economic security of people with mental illness

HOUSING	Increased investment in public and community housing with integrated support to provide more secure tenures for people experiencing mental illness
TRANSITIONS	Specific investment to ensure individuals with mental illness who transition from custodial environments and other forms of managed care, to access to stable housing and support to re-engage with education and employment
CAPABILITIES	Extend the application of the recovery model in mental health service provision to embed strategies that build the aspirations, skills and connections of people experiencing mental illness
ADVOCACY	That the Victorian Government advocate for greater income security for people with mental illness in receipt of social security, and for increased investment to facilitate inclusion in the NDIS

Strategies to create an accessible and culturally relevant support system

INFRASTRUCTURE	Not only increased hospital beds, but investment in the development to alternative sites at which people experiencing acute illness can present for advice and support
PLACE	Regional investment in collective impact to address systemic fragmentation and duplication between the clinical and specialised community mental health sectors and the interaction with the NDIS
WORKFORCE	Expand the peer workforce in the clinical and community sectors, with commissioning models that emphasis the recruitment of people from an Aboriginal and Torres Strait Islander (A&TSI) and culturally and linguistically diverse (CALD) background
GOVERNANCE	Create and/or expand governance structures in clinical and community service provision that empower consumers and survivors to participate in decision-making, the development and analysis of service models which meet their needs

The Brotherhood of St Laurence and Mental Wellbeing

The Brotherhood of St Laurence (BSL) is an independent non-government organisation with strong community links that has been working to reduce poverty in Australia since the 1930s. Based in Melbourne, but with a national profile, the BSL continues to fight for an Australia free of poverty. We undertake research, service development and delivery, and advocacy with the objective of addressing unmet needs and translating the understandings gained into new policies, new programs and practices for implementation by government and others.

Our practice experience in service delivery across multiple policy domains indicates the importance of addressing mental wellbeing and mental illness through mainstream provision. Service provision at the BSL entails a range of responses for individuals facing disadvantage across the life course, from the early years to working age, and into retirement. Many participants in our programs experience high levels of psychological distress and mental illness. Our approach to service design and delivery prioritises the provision of safe and welcoming environments for all participants. In addition to supporting access to specialised support when required, our service designs are structured to allow participants to reach their aspirations and achieve greater wellbeing. Some examples of such interventions follow:

- Early Years Programs that work to promote confidence and social connection: the Refugee Family/Child Outreach is a home visiting program that also works to foster connections, build skills and confidence among recent arrivals with parenting responsibilities. The program has been designed to address social isolation and build confidence in parenting skills thereby directly addressing the social determinants of health and wellbeing

- Education First Youth Foyers (EYFY) which provide student accommodation for young people at risk of homelessness, have been piloted on three TAFE campuses in Victorian. The structure of service provision is organised around six central service offers, including one focused on health and wellbeing. This kind of holistic and integrated support works to improve wellbeing and address mental illness, but not in isolation from addressing broader issues, including forging connections with mainstream services, civic participation and engaging in education to build aspirations and improve transitional outcomes

- BSL Work and Learning Centres provide an alternative to mainstream employment services for people living in public housing who struggle to engage with the labour market, and provide an integrated response to assist clients overcome barriers to employment that may arise due to challenges with mental health and wellbeing.

- Through the provision of Home Care Packages to older Victorians, we prioritise addressing social isolation alongside the provision of other funded supports to ensure improved emotional wellbeing and social connection, which are protective factors against the development of mental illness as people grow older.

Across these and other programs, the BSL actively works to support individual wellbeing. Our practice experience suggests that the broader community sector is central to the establishment of a mental health system that can address the social determinants of mental wellbeing, to promote

recovery and build capabilities for people who experience mental ill health. The design of mainstream services can be responsive to people with mental illness, and those who experience risk factors that may predispose them to high levels of psychological and emotional distress. The work of the broader community sector is thus central to any comprehensive approach to the establishment of an effective mental health system.

In addition to delivering the wide range of programs just mentioned, the BSL has an active Research and Policy Centre that conducts research into a) the multiple causes of poverty and social exclusion, and b) effective forms of systems change and policy reform that redress these issues. The following submission draws upon both our practice wisdom and research. Reforms to our system of mental health will only lead to improved outcomes if the poverty, exclusion and marginalisation are also addressed. The Royal Commission has the opportunity to design comprehensive and transformational policy response to mental illness in Victoria that will:

- Ensure all Victorians achieve greater wellbeing across the life-course;
- Increase social inclusion and economic security for people who experience mental ill health, and
- Create an accessible and culturally relevant system of support that balances clinical and community interventions to build the capabilities of people experiencing mental illness

The next chapter explores the conceptual foundations for policy design to this end. Subsequent chapters address some of the specific strategies to advance these objectives. Each discussion is limited to our areas of expertise and practice knowledge.

1 Developing a conceptual framework for the redesign of Victoria's Mental Health System

Understanding the conceptual challenge

This is not the first significant review of the adequacy of the policy settings and service provision that address mental illness in Australia. There have been numerous reviews and inquiries into the structure and effectiveness of supports for people with mental illness through specialist and mainstream clinical and community services. The findings have been coherent and consistent across decades:

- There is insufficient investment from all levels of government to address mental illness. There is a strong rationale for additional investment into specialised but interdisciplinary services, offered in the community, rather than through acute care facilities. These services should integrate physical and mental health support, alongside strategies to address social and economic disadvantage, with a view to long-term recovery and inclusion, building capability while addressing symptoms of illness.

- There are profound inequities in access to support across regions and socioeconomic groups. Stigma and discrimination may play a role, but these factors are compounded by regional economic factors. Place-based responses which are culturally and spiritually accessible, particularly for Indigenous Australians and those from refugee backgrounds, are required.

Proactive responsiveness to these weighty reports from all levels of Government notwithstanding, there is consensus that not enough progress has been made, and there is evidence that the Victorian system is near crisis. In this context, developing a coherent approach to the future of mental health support in the Victorian context requires a cogent conceptual framework to advance us beyond a fragmented approach to transformational systems reform. This requires consideration of the significance of:

- An inclusive definition of mental wellbeing, which incorporates but is not limited to the absence and management of mental illness

- Addressing poverty alongside other social determinants of mental health

- Ensuring adequate investment in promotion, prevention and early intervention using a life-course approach

- Extending the recovery approach to service provision with a capabilities approach.

An inclusive definition of mental health and wellbeing

Mental health is a core component of health and wellbeing. As stated in the Royal Commission's terms of reference, about 1.2 million people in Victoria (approximately 1 in 5) experience mental illness each year. Based on 2017 figures, approximately 11 per cent of the population will experience a mild mental illness, 6 per cent will experience a moderate mental illness, and a further

3 per cent will experience a severe mental illness each year.[1] In addition, in 2016 14.8 per cent of Victorian adults had high or very high levels of psychological distress.[2]

These figures are compelling but convey more certainty about the meaning of mental health and illness than is perhaps warranted. In a recent review of diagnostic systems, the British Psychological Association's Division of Clinical Psychology has argued that a disease construct based on mainstream medicine has limitations in its application to describe and explain forms of psychological distress and aberrant behaviour that attract the label pathological.[3] They point to ongoing controversies with the use of Diagnostic and Statistical Manual (DSM) and the Mental and Behavioural Disorders chapter of the World Health Organisation's Classification of Diseases and Related Health Problems. The purpose is not to discredit the significant advances that have been made in the treatment of mental illness, but to point out the evidence-base and thus our understanding of mental illness is continuing to evolve. Indeed as science progresses it is likely that out theoretical models of illness will continue to change.

Inquiring into the lived experience of both mental wellbeing and psychological distress can complement the utility of diagnostic system in developing a deeper understanding of both the precursors to illness and journeys to wellness. The BSL has been influenced by the extensive work that has been done to articulate social and emotional wellbeing from an A&TSI perspective, noting that similar work has been undertaken by first nation's peoples elsewhere. In an expansive discussion of social and emotional wellbeing, Gee et al submit that their analysis is based on a concept of the person which is more collectivist than individualist, is embedded in family and community.[4] The significance of this conception for the formulation of mental health policy and service design cannot be understated. It is an expansive conception that requires a response to the whole person, in the context of their relationships.

For these reasons and others to be discussed below, the BSL submits that the conceptual understandings of illness and wellbeing that support policy and clinical intervention must be informed by lived experience, accept divergent cultural constructs and explore the casual impact of social determinants, in addition to genetic, neurological and other biological factors. Any definitions of mental health and wellbeing employed by the Royal Commission should learn from the contributions of Australia's first people to this topic. Starting with a broad and inclusive definition of wellbeing, and it inverse, will focus the Royal Commission the social factors that promote wellbeing and are potentially modified by policy intervention, in addition to the treatment of illness.

Poverty and the social determinants of mental health

A strong body of evidence demonstrates that income inequality, discrimination and social exclusion, unemployment and underemployment, adverse childhood experiences and other markers of poverty can lead to poor health outcomes in general, and to disproportionately poor

[1] Greaves, A 2019, *Access to Mental Health Services*, 17.

[2] Department of Health and Human Services 2016, *Victorian Population Health Survey, 159.*

[3] Johnstone, L. & Boyle, M 2018, *The Power Threat Meaning Framework*

[4] Gee, G. et al. 2014, *Aboriginal and Torres Strait Islander Social and Emotional Wellbeing*

outcomes for certain groups of the population.[5] Recent analysis by the Productivity Commission shows that about 9 per cent of Australians experience recurrent and persistent poverty.[6] While research commissioned by VCOSS found that according to the after-housing equivalised income poverty line, 13.2 per cent of Victorians live in poverty.[7] In Victoria, socioeconomic disadvantage is the greatest cause of health inequality.[8] Such a health gradient is also evident in relation to mental health, with a higher prevalence of many mental health conditions in subpopulations with lower socioeconomic status.[9]

Nonetheless, interaction between mental illness and poverty is complex. Poverty predisposes people to other forms of trauma, including violence and homelessness, and is correlated with social exclusion and isolation. Mental illness encompasses conditions that are uniquely sensitive to life circumstances. Poverty and trauma are distal and direct causes of both mental illness and mental ill-health, disruptive to individual wellbeing at multiple levels. Income inequality is independently associated with depression prevalence,[10] and poverty and disadvantage have been found to have substantial negative effects on wellbeing and to increase the risk of common mental disorders.[11] Studies across the world have also consistently found an association between people in lower socio-economic groups and severe mental illnesses such as schizophrenia.[12] In Australia 1 in 4 of the poorest 20 per cent of the population have psychological distress at a high to very-high level, compared to approximately 1 in 20 people in the richest 20 per cent.[13] Analysis of 9 years of Household, Income, and Labour Dynamics in Australia (HILDA) survey data from 2001 to 2010 found that those people who reported deprivation and cash-flow problems had a greater risk of mental health problems than those who did not.[14]

Poverty and social exclusion are multidimensional and can also take non-monetary forms. Indicators of social exclusion may include low levels of education, poor health and access to care, inadequate housing, and exclusion from the labour market.[15] Research in the Australian context has shown that early onset of mental illness has negative consequences for educational attainment and transition to the workforce, with many young people who experience a mental illness not

[5] Shim and Compton, "Addressing the Social Determinants of Mental Health," 844.

[6] Productivity Commission, "PC News," 13.

[7] Robert Tanton, Dominic Peel, and Yogi Vidyattama, "Every Suburb Every Town: Poverty in Victoria," 8.

[8] Department of Health and Human Services, "Health and Wellbeing Status of Victoria: Victorian Public Health and Wellbeing Plan 2015–2019 Companion Document," 10.

[9] Fisher and Baum, "The Social Determinants of Mental Health," 1058.

[10] Shim and Compton, "Addressing the Social Determinants of Mental Health," 844.

[11] Jacka et al., "Prevention of Common Mental Disorders," 926.

[12] Saraceno, Levav, and Kohn, "The Public Mental Health Significance of Research on Socio-Economic Factors in Schizophrenia and Major Depression."

[13] Isaacs et al., "Lower Income Levels in Australia are Strongly Associated with Elevated Psychological Distress."

[14] Kiely et al., "How Financial Hardship Is Associated with the Onset of Mental Health Problems over Time," 909.

[15] Sylvestre et al., "Poverty and Serious Mental Illness," 156.

completing Year 12.[16] For young people, around 75 per cent of mental disorders have developed by the age of 24.[17]

The relationship between poverty and mental illness is bi-directional. Mental illness can result in deepening impoverishment, posing difficulties to maintain employment and tenancy, relationships and connections. While mental illness itself is caused by a variety of factors, individual and genetic, the research clearly shows that social determinants impact the prevalence and trajectory of mental illness.[18] In addition to social exclusion, isolation, stigma and discrimination may prevent a person gaining access to the services and support they need during an episode of mental illness.[19] These experiences are more likely for people in certain groups, including older Australians, women, immigrants from non-English speaking backgrounds, Aboriginal and Torres Strait Islander people, public housing tenants, and people with a disability.

People experiencing severe mental illness face a range of additional challenges. In Australia people with a psychotic illness are over-represented in homelessness statistics, with 5.1 per cent of participants in the Australian study 'People Living with Psychotic Illness' reporting homelessness at the time of the survey, compared to 0.5 per cent of the Australian population in the 2006 census. One quarter of participants in the same study expressed a fear of homelessness, and almost one quarter (22.7%) were on a public housing waiting list.[20] Despite this, there is nothing intrinsic to the experience of severe mental illness that links it with poverty. Instead, the social and political marginalisation of people with severe mental illness likely leads to a situation where poverty is accepted in this group.[21]

Addressing the social determinants of mental health

Emphasis on the social determinants of mental health is not lacking in the Australian policy environment. The National Mental Health Commission outlined a vision for a 'proactive strategically aligned system' that involved, among other things, 'shifting the centre of gravity of funding away from the acute, crises end, towards prevention, early intervention and community services which reduce the onset of illness, complications and crises'.[22]

In Victoria, the Public Health and Wellbeing Plan 2015-19 (VPHWP) has a clear focus on the social determinants of health and wellbeing at the population level, with mental health included as one of 6 key priority areas for action. In 2015 after the conclusion of the first VPHWP no gains had been

[16] KPMG and Mental Health Australia, "Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform"; Youth Development Australia, "A National Report Card on Youth Homelessness."

[17] KPMG and Mental Health Australia, "Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform."

[18] Lund, C et al. 2018, 'Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews', *The Lancet Psychiatry*, vol. 5, no. 4, pp. 357–69.

[19] Sylvestre et al., "Poverty and Serious Mental Illness," 156.

[20] Morgan et al., "People Living with Psychotic Illness 2010," 60.

[21] Sylvestre et al., "Poverty and Serious Mental Illness," 154.

[22] National Mental Health Commission, *Report of the National Review of Mental Health Programmes and Services*, 41.

made in reducing rates of psychological distress.[23] A new plan is currently being prepared by the Department, and we support an ongoing focus on the social determinants of health and wellbeing, and on mental health as a priority area.

Despite intentions, these important policy initiatives have not yet realised their potential. The Royal Commission has an opportunity to ensure adequate investment and strategies to address the social determinants of mental health are fully incorporated in any recommendations to the Victorian Government. What is important to note, and will be discussed further in the following chapter, is that addressing the social determinants of health requires a whole of Government and community approach. The responsibility does not fall neatly within the scope of mental health policy. Likewise with promotion, prevention and early intervention activities, discussed in the following section.

Promotion, prevention and early intervention using a life-course approach

Because mental wellbeing is so acutely sensitive to context and circumstance there is reason to hope that further promotion, prevention and early intervention can improve wellbeing, reduce the incidence of mental illness and the level of disability associated with the experience of it. The application of a life-course approach to this field has been described as concerned with "with the interplay of social and biological factors in the production and consequences of mental illness over the life span—from the prenatal period to death and across generations"[24]. Drawing on an interdisciplinary and developmental perspective, the importance of a life-course approach has become increasingly apparent for promotion, prevention and early intervention in mental health[25]

At each stage of the life-course an effective and encompassing strategy would first identify potentially modifiable risk and protective factors and design interventions accordingly.[26] Consultation with staff in our Aged Care division exemplified the significance of understanding risks that are specific to different phases in the life-course. The cumulative effects of poverty and inequality over the life course necessitate many people in their later years face complex service and personal needs. Histories of institutionalisation and abuse, homelessness, trauma, drug and alcohol abuse, disability, and a lack of healthcare support only serve to compound this effect. BSL's aged care services are committed to supporting this population in their later years. In addition to accommodation facilities and home care, we encourage older people to participate in activities that maintain and build social connection and community belonging. Central to this is a practice approach that builds the capabilities and agency of our service users to take control over the decisions which affect their lives- including their care plan.[27] Quality aged care, premised upon

[23] Department of Health and Human Services, "Health and Wellbeing Status of Victoria: Victorian Public Health and Wellbeing Plan 2015–2019 Companion Document," iii.

[24] Koehen K. 2013.

[25] Mikkelsen. 2019.

[26] Jacka et al., "Prevention of Common Mental Disorders," 921.

[27] Kimberley, Gruhn and Huggins. 2012. Valuing capabilities later in life: the capability approach and the Brotherhood of St Laurence aged services.

interpersonal service delivery and interconnected health and social services that promote equity, inclusion, and quality of life is core to BSL's work with older people.

In BSL's service experience, older people living in the community are often at risk of profound social isolation, inextricably linked to declines in physical and mental health.[28] Recent consultation with our home care case managers reveal events like widowhood, dealing with the loss of friends or having to care for a partner or family member can be key contributors to feelings of isolation and poor health. Even as fulltime carers, older people can still suffer from social exclusion. For older people who lack the social support, capacity, and resources to navigate the current marketised system of aged care, meeting basic needs can be difficult.[29] This is not to say older people cannot live independently; rather support is required to self-direct their care. Bridging social capital between external organisations is therefore a critical component of our practice and service delivery across our suite of aged care services.[30]

All this means that it is still possible to intervene in ways that prevent the onset of mental illness later in life. Promotion, prevention and early intervention is relevant across all phases of the life-course. But needs to be calibrated accordingly.

There is an important point of intersection between advocating a life-course approach to promotion, prevention and early intervention and with the previous discussion of the social determinants of mental health and wellbeing. Risk and protective factors occur at the individual level, but have antecedents in the structures of communities, services, markets and employment. The collective risks factors that occur at a population level include many of the social determinants discussed above, including poverty, underemployment and unemployment, housing precariousness and homelessness. [31]

The BSL submits that in the development of its recommendations about promotion, prevention and early intervention, the Royal Commission give regard to developmental risk factors across the life course, and consider further interventions at key transition points to complement the commitment to address the social determinants of health.

Extending the recovery model with the capabilities approach

Over the last 20 years the Recovery Model has entered mainstream policy and practice as a way of reframing mental health prognoses from a focus on symptom remission to emphasising a person's strengths, capacities and abilities and valuing the knowledge and experiences of people with lived experience of mental illness. The approach aims to support people to find a way to live a satisfying,

[28] Aged and Community Services Australia. 2015. Social Isolation and Loneliness Among Older Australians, Issue Paper.

[29] Simons, B, Kimberly, H & Jones NM 2016, *Adjusting to consumer directed care: the experience of Brotherhood of St Laurence aged care service users*, Brotherhood of St Laurence, Melbourne.

[30] Wickramasinghe, S & Kimberley, H 2016, *Networks of care: valuing social capital in community aged care services*, Brotherhood of St Laurence, Fitzroy, Vic.

[31] Jacka et al., 921.

hopeful, and contributing life - even within the limitations caused by illness.[32] This focus on promoting personal goals is advantageous for subjective wellbeing.[33] In Australia the Recovery model was embedded in national policy in the *2013 National Framework for Recovery Oriented Mental Health Services*, while Victoria was an early adopter with the 2011 *Framework for Recovery Oriented Practice*. The introduction of these policies was a major achievement, and it signals strong support for the participation and voice of people with mental illness in all facets of the mental health system. Nonetheless there have been impediments to the full realisation of the recovery model within clinical services. The service system operates through eligibility processes that determine service access, which in the mental health system typically requires a diagnosis and often returns the emphasis to the medical model of mental illness, which can be in tension with the goals of personal recovery.[34] The model still 'favours psychiatric over social care',[35] and has insufficient regard for the 'structural causes of inequality'.[36]

The recovery model faces challenges at the level of implementation:

- A "recovery gap" is frequently identified between the aspirations of people with lived experience and the willingness or capacity of workers and the systems they work in to enable this[37]
- The Recovery Model lacks the tools to address macro level factors that may be sources of social injustice such inequality, stigma and discrimination[38]
- An emphasis on individual-level services and programs may have come at the expense of the need for environmental accommodations and broader social change[39]

Recovery Model has evident capacity to positively affect subjective wellbeing through a strengths-based approach that supports self-determination and recognises the value of lived experience. But in order to address the limitations stated above, we would supplement it with the capabilities approach developed by Amartya Sen and Martha Nussbaum. This approach is core to much of the BSL's work. The approach is configured by normative commitments to human freedom and flourishing. The approach is cognisant that support for individual functioning, or human capital, is necessary but not always sufficient to achieve just outcomes. Adjusting opportunity structures, through policy and systems reform, can be just as important.

[32] White, Imperiale, and Perera, "The Capabilities Approach," 2–3.

[33] White, Imperiale, and Perera, 3.

[34] Davies and Gray, "Mental Health Service Users' Aspirations for Recovery: Examining the Gaps between What Policy Promises and Practice Delivers" 49.

[35] Davies and Gray, 50.

[36] Davies and Gray, 51.

[37] White, Imperiale, and Perera, "The Capabilities Approach," 3.

[38] White, Imperiale, and Perera, 3.

[39] Sylvestre et al., "Poverty and Serious Mental Illness," 161.

From this perspective, practice approaches may intervene at the individual level to increase capabilities 'by increasing knowledge, building skills, or minimizing disability'.[40] But of equal importance is directing 'attention at changing the environmental barriers that restrict capabilities or [working] to increase opportunities'.[41] Capabilities therefore are not only an attribute of the individual (such as knowledge and skills and personal qualities), but they also refer to access to the resources that an individual needs to make choices, and the extent to which individual, social and environmental arrangements make it possible for the exercise of choice.[42] This provides a way to analyse and solve problems that relate to the intersection between mental health and poverty. From a capabilities perspective, 'poverty is the deprivation of capabilities rather than limited economic resources'.[43]

The introduction of a Capabilities Approach to mental health practice would bring into scope questions around whether a person has access to resources or capital (be that economic, material, social, cultural, intellectual), and access to the opportunities which support the development of capabilities[44]. This has implications for both service design and outcomes measurement. Even specialist service design should entail multiple offerings that encompass the whole person and address structural impediments to realising aspirations and developing capabilities. Assessing outcomes should include an individual's perspective, i.e. is it valued, meaningful, and sustainable, and should also measure the extent to which the service environment is accessible and supports protective factors linked to positive mental health.

Conclusion

There are undoubtedly many factors the Royal Commission will consider in the development of a framework to improve outcomes and the experiences of people with mental illness in Victoria. Nonetheless, the BSL recommends that the Royal Commission give particular regard to the following factors discussed above:

- An inclusive definition of mental wellbeing, which incorporates but is not limited to the absence and management of mental illness
- Addressing poverty alongside other social determinants of mental health
- Ensuring adequate investment in promotion, prevention and early intervention using a life-course approach
- Extending the recovery approach to service provision with a capabilities approach.

[40] Sylvestre et al., 157.

[41] Sylvestre et al., 157.

[42] Wheelahan, Leesa, "Vocational Education in Crisis: Why We Need a New Social Settlement," 15.

[43] Sylvestre et al., "Poverty and Serious Mental Illness," 156–57.

[44] White, Imperiale, and Perera, "The Capabilities Approach," 4.

2 Wellbeing, social inclusion and economic inclusion for all Victorians

This is an ambitious goal which does not diminish its relevance for this Royal Commission. Achieving greater wellbeing for all Victorians, and greater social and economic inclusion for people with mental illness in particular, will have a real impact on the social determinants of mental health and journeys to wellness. Although there are many pathways to this outcome, the focus of the following discussion is on principles for the design of inclusive mainstream services that are inclusive of people with mental illness and those with high levels of psychological distress, and use a capabilities approach to simultaneously address some of the social determinants of mental illness.

Principles for service design

The following discussion draws extensively on the BSL's experience designing and delivering innovative services for people experiencing marginalisation across the life-course. Our experience demonstrates that principles and practices structuring service design and delivery are of central importance to ensure inclusion and accessibility for people experiencing distress and illness. Our programs address the social determinants of mental health in multiple ways, and promote wellbeing more broadly by creating the conditions for human flourishing.

Key lessons include that:

- Accessibility and inclusion for people experiencing mental illness and/or high levels of psychological distress is increased by skilled and well-supported staff and the provision of physical spaces that are welcoming
- Services that focus on building the capabilities of individuals to pursue aspirations and connect with education and employment, promotes wellbeing across the life-course promote wellbeing outcomes. The BSL designs programs with multiple service offerings to allow for just such a responsiveness to individual aspiration while advancing social inclusion and economic security for participants
- The explicit inclusion of psychological support in many services, and the use of warm referrals in others, suggests a greater potential for the integration of mental health support in more mainstream community services
- Engaging in community development processes to support the design and delivery of community-based interventions, can work to promote protective factors by providing greater opportunities for social connections.

Staff and space

The BSL delivers Transition to Work (TtW) for young people who have become disengaged from education and lack a clear pathway to employment. Resourcing staff to coach young people is central to the approach that we have developed through a Community of Practice that includes 11 TtW providers across Australia. Case management often focuses on the problems, risks, or needs. While these factors are important, we seek to shift this approach by investing, coaching and supporting young people to develop a greater sense of personal agency over their lives and their

future. This requires holistic and integrated support to overcome barriers to participation and overall wellbeing.

The model is underpinned by an innovative practice approach which builds the motivation and agency of young people according to their talents and aspirations through the provision of opportunities, resources and networks that build their capabilities. Supplementing this practice approach is four structured phases of service delivery provided by a team of multidisciplinary coaches. [45] The first, and arguably the most important, centres upon self-exploration where young people reflect on their values, interests and talents. This phase is critical for many young people entering the service, but particularly for those disengaged due to anxiety, depression, or low self-esteem.

One participant reflected on their time entering the TtW service after leaving school due to mental ill health. This case study exemplifies the importance of skilled and motivated staff working with a program designed to provide holistic support and a practice framework that is attentive to the complex needs of individuals:

So I contacted [the service] and the plan was to go find work and then just better myself as a person. So I got with Rebecca, one of the youth development coaches here, and that was the plan until I told her my story, what's been happening, and then the focus was just to focus my mental health first, get me healthy, and then figure out what we want to do…So this program, I think it really helps with not just looking for work but – because that's obviously the program right, Transition to Work, and she really wanted to focus on my mental health and I think that helped a lot to help me get better.

Services that focus on building capabilities

Micro enterprise programs are another avenue in which BSL seeks to provide financial and emotional wellbeing across the adult years. Micro-enterprises provide valuable work experience and on-the-job-training for those excluded from the labour force, or those who have had marginal attachment to it.[46] In 2011, with support from government and philanthropic funding, the BSL launched Stepping Stones - a micro-enterprise program for women of refugee and migrant backgrounds. In addition to supporting economic participation and financial capabilities, the program's focus on networking opportunities and mentoring and support, produced progressive outcomes such as increased confidence, social connection, and community participation.[47] Central to this success is Stepping Stone's practice framework which recognises and values the determination, skills, and resilience of women from refugee and migrant backgrounds. This had a profound effect on the self-confidence, empowerment and overall mental health of participants.

As explained by one participant:

I arrived in Australia in 2008. I had a successful career as a chef but suffered a breakdown in 2017 and became too anxious to leave the house. I started the Stepping Stones program in 2018 with strong encouragement from my husband. I have experienced real change in my life since. The ongoing support offered to me from program staff and my mentor has had a huge positive impact

[45] Brotherhood of St Laurence 2018, *A fit-for-purpose national youth employment service,* 28-30

[46] Wickramasinghe, S & Bowman, D. 2019. *Not simply business as usual,* 7

[47] Bodsworth et al. 2014. *Being around other women makes you brave*, 29

on my mental health. I attended the program regularly and as the weeks passed I started to find my voice as it was a safe and familiar place from me. My anxiety levels reduced. I was able to start finding the confidence to attend new places and even use past skills to start a food business and sell at markets. I am now better able to cope and manage my anxiety. I feel so much more confident now than two years ago. I have made new friends from Stepping Stones and meet with them regularly. This has really helped me to have a lot more capacity and I genuinely feel so much happier.

The strengths-based and gender-aware practice framework necessitates an understanding of these women's circumstances through not only gender and race, but experiences of displacement and relocation.[48] It is well recognised the post-migration experience contributes to various social determinants of health, with positive mental health playing a pertinent role in successful settlement processes.[49] Given unemployment and a lack of social integration are key attributes to mental disorders experienced by long term refugees and migrants, any service provision seeking to secure economic pathways for this cohort must recognise the interaction between social circumstances and mental health.[50] The above examples also reiterates the importance of providing a safe space in which people can explore their aspirations and build capabilities.

Inclusion of psychological support in non-specialized services

Alternative learning settings are another avenue where the BSL works to meet the not only the learning, but also the health, welfare, and social needs of young people from disadvantaged backgrounds. Our David Scott School (DSS) delivers the VCAL program for young people who have been marginalised from mainstream education. The School balances interventions across there domains: teaching and learning; pathways and transitions; and wellbeing. Fostering a sense of connection and belonging in the school environment is given prominence as a protective factor for adolescent health and mental wellbeing.

Staff shared the following powerful example of the approach, which exemplifies that it is possible to address mental health issues while maintaining connection with education:

A young man of 18 with a low prevalence mental disorder was sitting by himself and exhibiting problematic behaviour at TAFE. The TAFE were concerned and contacted DSS. A wellbeing staff member made several attempts at outreach and got in contact with the young person's Nan. The young person lives with his mother, but his Nan had noticed that he had begun to make alarming and provocative statements. Through discussions with the student and his family it was decided that he was unable to focus on education at that time. As a result, the education component moved into the background and the youth and family practitioner stepped in. A number of steps were taken to provide the support required to enable the young man to return to a focus on his education. A meeting was held with key stakeholders to ensure supports were appropriate and targeted; he was supported to see a psychologist; a graduated return to class was planned; once back at school his timetable was arranged to enable him to make contact with the wellbeing officer every day. These

[48] Ibid, 12.

[49] Hynie, M 2018, *The Social Determinants of Refugee Mental Health*, 299

[50] World Health Organisation 2018. *Mental health promotion and mental health care in refugees and migrants, 4.*

steps have enabled him to return to a focus on his education and to progress with his objective of working in hospitality.

This is an example of early intervention in a non-mainstream school environment.

Community development

Building and maintaining healthy and resilient communities is pivotal to the BSL's commitment to foster economic security and social inclusion. Initiated at our Jindi Family and Community Centre, the 1000 Voices community development project was established in collaboration with local government to foster mental health and wellbeing among local communities. The project trains emerging community leaders to identify the strengths and needs of their community to generate community led activities to foster a sense of belonging and connectedness.

The Punjabi community from one site identified their need for intergenerational parenting discussions. Our bicultural worker recruited a local volunteer to run discussion groups with parents and grandparents who normally waited outside while their children attended Saturday dance classes. The volunteer led an eight-week program with 27 participants from the Indian community. People shared their experiences and learnt from each other. One participant shared the following insights which are a testimony to the importance of this approach: *It is very important that family members speak to each other openly. I have seen two suicides in my own community here in Melbourne. Our kids are first generation migrants and undergoing a lot of pressure, but they don't speak about the stress, pressure openly. Coming to these sessions with our kids gives us a platform, confidence and encouragement to share our views. You can imagine how happy I am with this program as I have attended all the sessions*.

Further to the partnership approach

All of the above examples illustrate that intentional service design and practice development that produce an integrated response to the whole person, regardless of identified needs, and entry criteria can advance wellbeing and provide a site for effective early intervention for people who have experienced high levels of psychological distress even in the absence of a formal diagnosis of mental illness.

Any reform to Victoria's mental health system requires a direct and intentional partnership with the broader community sector. A comprehensive approach to prevention and early intervention that is designed with reference to both the social determinants of health and the specific risk factors relevant to the different phases of the life course, requires a whole of government and whole of community response. This is not something that the clinical or specialised community mental health sectors can achieve on their own. As argued in the previous chapter reforms to the mental health system can lead to improved outcomes when coupled with strategies to address inequality and marginalisation, but are less likely to success if not complemented in this way. The work to overcome disadvantage and marginalisation is significantly, but not exclusively, undertaken by the community sector which must be considered key partner of the mental health system.

The Royal Commission has an opportunity to recommend that the Victorian Government commission community services that function to enhance the wellbeing of Victoria, thereby contributing to the prevention of mental illness. This can happen through the design of policies and

programs that features a commitment to multifaceted service offers that address the complexity of disadvantage. Engagement with individual aspirations in the pursuit of social inclusion and economic participation is a key principle of the capabilities approach that we enact and embed in service design. Our experience indicates the importance of including the following factors the design and delivery of community services to complement the reform of the mental health system in Victoria:

- That staff are trained in inclusive practices, attentive to evidence of psychological distress with the capacity to respond appropriately
- That sites for service delivery are constructed to promote cultural and psychological safety
- That service design is multifaceted to build the capability of the whole person, rather than fragmented or based on a deficit-based response to particular issues
- That psychological support is explicitly integrated in the design and delivery of community programs to foster easier access to specialised mental health services
- That service design also incorporate community development, in addition to individualised forms of delivery, to foster social connection.

Economic security and social inclusion for people with mental illness

Adherents to the recovery model in mental illness have long advocated that social inclusion and economic security are essential parts of the recovery journey.[51] The previous chapter explained that people with mental illness experience higher levels of social exclusion, poverty, homelessness and joblessness. The Victorian Government has significant leverage to improve the experience of people with mental illness attain housing security and access to education and employment, all of which are catalysts for economic security and social inclusion. But ensuring the centrality of these outcomes to the mental health system is a work in progress.

AHURI have recent published extensive analyses of the challenges some people with mental illness face attaining housing security. The recommendations for change are manifold and illustrate that the provision of secure and appropriate housing for people with mental illness is not only cost effective, pacing less pressure on the hospital system, but also stimulates recovery. Indeed, for persons experiencing homelessness who have been admitted to hospital with mental health diagnosis, the provision of public housing has been shown to decreases emergency department presentations, substantial decreases in psychiatric admissions and an estimated $84, 135 per person in health savings. [52]

A major impediment to this outcome is the simple lack of appropriate housing options. As of March 2018, the Victorian Housing register for public and community housing was sitting above 82,000 people, with almost 25,000 of those being children.[53] In the 2018/19 state budget, the proportion

[51] Bateman, J & Smith, T 2011, *Taking Our Place*.

[52] Wood, L., Flatau, P., Zaretzky, K., Foster, S., Vallesi, S. and Miscenko, D. (2016) *What are the health, social and economic benefits of providing public housing and support to formerly homeless people?*

[53] Legal and Social Issues Committee 2018, *Inquiry into the Public Housing Renewal Program*, 23

of social housing in Victoria decreased; not only does this decline in Victoria's public housing stock reflect a trend over the last ten years, it has secured Victoria's position as the lowest proportion of social housing units per capita of all Australian states – 1.5 percent below the national average.[54] This absence of funding is most acutely captured by Victoria's per person spending on social housing which was half the national average in the last financial year, equating to $82.94 per person compared to the national average of $166.93.[55] Even across the private rental market, only 148 properties across the state were affordable to a single person living on Newstart this March quarter.[56] Affordable housing supply is simply not meeting demand and while homelessness is not a choice, the level of homelessness is. In the absence of effective measures to address the critical shortage of social and affordable housing, reforms to the structure of mental health services will have limited effects.

Systems reform at the intersection of the clinical mental health and social housing sectors is equally important, as the Victorian program Doorways illustrates[57]. In addition to the immediate need to increase funding for homelessness services and increase the stock of public and social housing, there is an additional need to invest in innovative housing services that overcome the fragmentation in the provision of support for people with mental illness, particularly following periods of hospitalisation. The literature contains many models, which have been evaluated with varying degrees of success[58]. The Royal Commission provides an opportunity to increase the investment in the expansion of programs that can support people with mental illness into secure housing.

[54] Council to Homeless Persons, Media Release, 1 May 2018

[55] Michael, Luke. *More than 80,000 Victorians on Social Housing Waiting List* June 6 2018. Accessed June 26 2019. Available from https://probonoaustralia.com.au/news/2018/06/80000-victorians-social-housing-waiting-list/

[56] Victorian Government Department of Health and Human Services, 2019, *Rental Report March Quarter 2019,* p.19

[57] https://www.wellways.org/our-services/doorway

[58] Brackertz, N., Wilkinson, A., Davison, J. (2018) *Housing Homelessness and mental health: towards systems change*

3 Reform of the clinical and specialised community mental health sectors

Context: a system in need of reform

Fragmentation, service duplication and insufficient levels of support, these are consistent and persistent complaints directed at both clinical and community-managed mental health support sectors, which nonetheless do not speak to the intentions nor the capabilities of people working within those systems. Continued and increased investment is a necessary but not a sufficient condition for improvements. But the Royal Commission has an opportunity to explore further systems level reform at the points of intersection between these systems, remodelling the frameworks for provision of specialised support.

The clinical system

In 2016-17 only 2 out of 3 people with a severe mental illness were able to access the specialised mental health services they required from the public system.[59] And despite a large increase in the use of non-clinical mental health services through federally funded programs like Better Access (primarily accessed by those with mild or moderate mental illnesses), analysis of national data over the period between 2006 and 2015 found that this had no detectable effect on the prevalence of very high psychological distress or the suicide rate.[60]

In Victoria, the clinical mental health system is under extreme strain and is unable to meet the demand placed on it for specialised mental health services.[61] In Victoria emergency department (ED) presentations for mental health problems have increased 9 per cent from 2015–16;[62] in 2016-17, 14.6 per cent of people who had an overnight stay in a psychiatric hospital were re-admitted within 28 days;[63] and only 65.3 per cent of people who spent a night in a psychiatric hospital received a contact from a community Area Mental Health Service (AMHS) in the 7 days following separation,[64] which is the lowest of all states and territories. This suggests that people are not getting support until they have reached crisis point, that their stay in hospital may be insufficient in duration or unable to address underlying factors related to their mental illness, and that follow up post-discharge is inadequate and relapse is likely.

While recent injections of funding into Victoria's clinical mental health system announced in the 2019 state budget are welcome, they do not go far enough. Given that Victoria's real expenditure on specialised mental health services per person is the lowest of all States and Territories,[65] the long-term underfunding of the system has resulted in a chronically under resourced system that in

[59] Australian Institute for Health and Welfare, "Mental Health Services in Australia," Table KPI.8.1.; Royal Australian College of Psychiatrists, "Mental Health: Targeting New Investment," 2.

[60] Jorm, "Australia's 'Better Access' Scheme," 1057.

[61] Greaves, Andrew and The Victorian Auditor General's Office, "Access to Mental Health Services."

[62] Greaves, Andrew and The Victorian Auditor General's Office, 11.

[63] Steering Committee for the Review of Government Service Provision, "Report on Government Services 2019," 13.A.34.

[64] Steering Committee for the Review of Government Service Provision, 13.A.32.

[65] Steering Committee for the Review of Government Service Provision, 13.A.9.

too many cases is unable to intervene early enough to provide the treatment and support that people with mental illness require.

Victoria's 10 Year Mental Health Plan recognises that increased demand has not been matched by increased resources, with the result that wait times are longer, thresholds for access are higher, and people are less likely to receive services when they need them.[66] The Victorian Auditor General's report on access to mental health links these problems to a lack of clear understanding of system capacity, and lack of clear estimates for current and future service demand, recommending DHHS undertake a thorough systems map of capital and workforce infrastructure and the geographical spread of services, and use this to inform a statewide investment plan that includes deliverables and timeframes.[67]

Community-Managed Support

Another vital component of Victoria's mental health sector is the community-managed mental health (CMMH) system. During the period when the Psychiatric Disability Rehabilitation and Support Services (PDRSS) program was running Victoria's CMMH system was the largest non-government mental health sector in Australia.[68] The introduction of Victoria's Mental Health Act in 2014 saw reforms to the sector that consolidated CMMH services under the Mental Health Community Support Services (MHCSS) program. MHCSS programs, as well as federally funded CMMH programs such as Partners in Recovery (PIR), Personal Helpers and Mentors (Phams), and Day to Day Living (D2DL), do critical work intervening early and keeping people well. In 2015-16 the MHCSS program was expected to provide support to more than 12,000 people.[69]

CMMH services complement the work of public and private clinical mental health services.[70] The wide range of support services and activities provided through CMMH organisations include 'counselling, homebased outreach, advocacy services, family and carer support, leisure and recreation, health care and fitness, vocational training and employment support, accommodation support, respite, and peer support and consumer-operated services'.[71] Outreach strategies may include the provision of psychosocial recovery oriented support to people experiencing mental ill-health, their families and carers, to reduce social isolation, develop skills and build confidence, provide support to accomplish day to day tasks and enable a person to live a meaningful life. Importantly, community organisations are well-placed to deliver such services because of their emphasis on 'personal relationships and holistic service provision'.[72]

[66] Department of Health and Human Services, "Victoria's 10-Year Mental Health Plan," 10.

[67] Greaves, Andrew and The Victorian Auditor General's Office, "Access to Mental Health Services."

[68] Department of Human Services, "An Introduction to Victoria's Public Clinical Mental Health Services," 16.

[69] Department of Health and Human Services, "Victoria's 10-Year Mental Health Plan," 8.

[70] Bateman and Smith, "Taking Our Place."

[71] Bateman and Smith, 57.

[72] Davies and Gray, "Mental Health Service Users' Aspirations for Recovery: Examining the Gaps between What Policy Promises and Practice Delivers.," 49.

However, national data about the activities of mental health NGOs and their workforce are not currently collected on a routine basis in Australia[73], which makes it difficult to gather a clear picture of Victoria's CMMH system and its performance relative to other states and territories.

The transition to the NDIS saw funding for MHCSS programs withdrawn and reallocated to the NDIS. The COAG agreement ensures people accessing MHCSS are automatically eligible to access the NDIS, and at June 30, 2018 there were 4,389 Victorians with a primary psychosocial disability accessing NDIS support.[74] However, there are currently no statistics indicating how many people have transitioned from MHCSS programs, and whether they have received NDIS plans that meet their needs. Initial data on the number of people who transitioned to the NDIS from federally funded CMMH programs indicates that as few as 25 per cent of those who were accessing those services now access equivalent services under the NDIS.[75]

Where to now?

If the directions for reform articulated by this submission were implemented, enabling the Victorian Government to work in close partnership with agencies committed to addressing the social determinants of mental health, to build the capabilities of people with mental illness through economic security and social inclusion, the kinds of systems failures described above would decrease and possibly have less impact.

Additionally, however, investment at the intersection of the clinical and specialist community managed sectors could reshape the experience of people with acute episodes of illness and transform their journeys back to mental health. For example there is a possible solution to the persistent dilemma about the allocation of public hospital beds for psychiatric care. In 2015-16 across Australia, 3.7 percent of presentations to public hospital emergency departments (ED) had mental illness as a principal diagnosis, approximately 40 percent were admitted to the hospital for further treatment.[76] The reasons for such presentations are complex. Nonetheless there are good reasons to consider that such presentations are, in part, a result of system weaknesses: that individuals who seek help do not have other support networks or alternative services through which to obtain assistance, the absence of effective early interventions is also at issue. Public psychiatric hospital beds are scarce, and there is some evidence that many are occupied by people who should be treated by more suitable lower cost services. Moreover, there is evidence that alternative receiving environments can promote better outcomes.

[73] Australian Institute for Health and Welfare, "Mental Health Services in Australia," 28.

[74] Department of Health and Human Services, "Victoria's Mental Health Services Annual Report 2017-18," 26.

[75] Digolis et al., "Tracking Transitions of People from PIR, PHaMs and D2DL into the NDIS: Commonwealth Mental Health Programs Monitoring Project - Interim Report."

[76] AIHW 2018 Mental Health services provided in emergency departments https://www.aihw.gov.au/getmedia/1ffc85db-f620-48e8-8d94-57a375e132fe/Mental-health-services-provided-in-emergency-departments.pdf.aspx

- The Alameda Model is a dedicated psychiatric emergency service developed in California, offered adjacent to hospital EDs. There is evidence that the Model reduces wait times and improves patient care.[77]
- Illinois has developed *The Living Room* as an alternative to hospital ED[78]. An exploration of the lived experience of people with access to the Living Room found that *guests* reported feeling safe and welcome. The design of the Living Room built on previous research that suggested that individuals were well supported in consumer-managed and community-based crisis responses[79].

The development of alternatives models to address care needs at crisis requires a significant investment in infrastructure and research[80]. But the evidence indicates that there are alternative ways of working which can be effective, simultaneously reducing pressures on the public health system while improving the lived experience of people with mental illness. Victoria has a unique opportunity to investigate and trial such alternatives. Now is the time to imagine, implement and evaluate interventions to transform the hospital sector and improve the lived experiences of people with mental illness that access these for support. Undoubtedly such an approach will require regional specificity. A comprehensive response would complement an infrastructure spend with investment in the creation of regional forms of collective impact to mobilise agents and organisations across sectors to drive significant reform in the levels and type of collaboration across sectors and segments of the health system. There are some institutional and programmatic responses in place auspiced by Primary Health Networks and Partners in Recovery. Nonetheless, further reform to the clinical services offered through public hospitals has the potential to accelerate the transformation of service fragmentation, particularly the uniquely vulnerable individuals who present and EDs for care and support.

[77] Zeller, S, Calma, N, & Stone, A 2014, "Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments", *The western journal of emergency medicine*, *15*(1), 1–6. doi:10.5811/westjem.2013.6.17848

[78] Fischer, T 2015, "Why the U.S Mental Health Care System Needs More Places for People Just to Chill Out: https://www.mic.com/articles/109946/our-mental-health-care-system-needs-more-places-for-people-to-chill-out

[79] Shattell, M. M, et al. 2014, "A Recovery-Oriented Alternative to Hospital Emergency Departments for Persons in Emotional Distress: 'The Living Room'." Issues in mental health nursing 35(1): 4-12.

[80] Centre for Clinical Effectiveness. 2017. Models of Care for Mental Health in ED: Scoping review. Centre for Clinical Effectiveness, Monash Innovation and Quality, Monash Health, Melbourne, Australia.

4 Conclusion

The foregoing discussion has illustrated that both investment and innovation in the structures that support mental health, is a must. Now is the time to be bold. To this end the BSL commends the following strategies and actions to the Royal Commission

Strategies to achieve greater wellbeing across the life-course

PROMOTION	Increased support for population-wide mental health promotion structured with reference to risk and protective factors at different stages in the life-course
GOVERNMENT SERVICES	Embedding evidence-based practices that support improved wellbeing outcomes across all forms of Victorian government service provision, not just specialised mental health services
COMMUNITY SUPPORT	Increased investment in community-based programs and initiatives that address the social determinants of mental health and wellbeing
INDUSTRY ENGAGEMENT	Greater support for employers to develop and implement wellbeing policies for staff, clients and consumers

Strategies to increase social inclusion and economic security of people with mental illness

HOUSING	Increased investment in public and community housing with integrated support to provide more secure tenures for people experiencing mental illness
TRANSITIONS	Specific investment to ensure individuals with mental illness who transition from custodial environments and other forms of managed care, to access to stable housing and support to re-engage with education and employment
CAPABILITIES	Extend the application of the recovery model in mental health service provision to embed strategies that build the aspirations, skills and connections of people experiencing mental illness
ADVOCACY	That the Victorian Government advocate for greater income security for people with mental illness in receipt of social security, and for increased investment to facilitate inclusion in the NDIS

Strategies to create an accessible and culturally relevant support system

INFRASTRUCTURE	Not only increased hospital beds, but investment in the development to alternative sites at which people experiencing acute illness can present for advice and support
PLACE	Regional investment in collective impact to address systemic fragmentation and duplication between the clinical and specialised community mental health sectors and the interaction with the NDIS

WORKFORCE	Expand the peer workforce in the clinical and community sectors, with commissioning models that emphasis the recruitment of people from an Aboriginal and Torres Strait Islander (A&TSI) and culturally and linguistically diverse (CALD) background
GOVERNANCE	Create and/or expand governance structures in clinical and community service provision that empower consumers and survivors to participate in decision-making, the development and analysis of service models which meet their needs

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