Victorian Government: Royal Commission into Mental Health
Terms of Reference Consultation

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Mind Australia

Mental Health Royal Commission Establishment
Department of Premier and Cabinet
GPO Box 4509
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Introduction

Mind Australia Limited (Mind) is one of Australia's largest community-managed mental health providers, operating in multiple states. In Victoria, we have been supporting people dealing with the day-to-day impacts of complex mental illness, as well as their families, friends and carers since 1977. These are our primary clients.

We provide high quality services, with a reputation for innovation in service development. We are a leader in delivery of a wide range of recovery-oriented services to people with complex mental illness and specialised psychosocial disability services including dual disability. We are the largest non-government organisation (NGO) provider in Australia of sub-acute services run in partnership with clinical mental health services. Mind also plays a major role in assisting people to access affordable housing and supporting them to live independently. We provide a range of specialist services: sub-acute residential recovery care; supported independent living; group education; group recreation; allied health and counselling; one-on-one outreach; complex and behavioural support; family and carer services; and telephone helplines and online forums. We also have an active research program and a dedicated policy advocacy function. In the 2017/18 financial year, we supported around 8,000 individuals in Victoria alone.

This submission will outline the issues that we believe the Commission should address:

- Adopt a human rights framework to guide the inquiry
- Centre the voices of people with experiences of mental ill-health
- Treat different ways of knowing about mental ill-health and recovery equally
- Include in scope all social determinants of mental ill-health
- Examine the impact of State/Commonwealth arrangements on individuals
- Ensure an equal focus on clinical and community-managed mental health services
- Explore expanded roles for community-managed mental health services
- Explore expanded roles for the peer workforce and peer-led services
- Listen to people's negative experiences of mental health services
- Examine the intersections with other concurrent national inquiries

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General comments and background

Mind strongly supports the establishment of a Victorian Royal Commission into mental health (henceforth the Commission), and we welcome this opportunity to contribute to the design of the Commission's terms of reference. We wish to promote a human rights based operational framework, together with ten key recommendations on the scope and process that Mind considers to be of critical importance.

We also wish to acknowledge the complexity involved in managing a public inquiry of this scale. The architecture of the Commission, including the Terms of Reference (ToR) and the Commission's governance structures must be sufficiently robust and transparent so as to manage the vast expectations of many Victorians.

As a preliminary observation, the establishment of this Commission closely follows the Victorian Government's September 2018 commitments to provide an additional $70 million to the community mental health sector, and a further $49.5 million to support Victorian carers needing respite. This recent political and fiscal momentum, whilst welcome, must properly be placed within a far wider context. As Premier Andrews commented publicly in October 2018, "*we have a* [mental health] *system that simply can't cope and will continue to contribute to tragedy if we don't have a royal commission and seek those answers, make that reform, drive that change and show that leadership*"[1]. We concur, although believe it would be more accurate to refer to *multiple* systems, rather than a single mental health system. From its status as a world leader in specialist mental health services in the 1990s and 2000s, Victoria now has the lowest per person expenditure on specialised mental health services in Australia[2]. From a systems and services perspective, Victoria has multiple, overlapping systems of mental health care, treatment, prevention, promotion and support. All of these are undergoing significant and disruptive structural changes that sit alongside the longstanding complexity of a federated system in which health policies and funding streams are dispersed across Commonwealth and State government.

Framework for the Commission

An inquiry into mental health has to respond to a very broad field of possibilities: for instance, at one end of the spectrum, it could focus on the role played by the pharmaceutical industry in tackling mental ill-health, whilst at the other end, it could focus on alternative approaches such as meditation, mindfulness and animal therapy. To tackle this situation, there are a variety of possible frameworks that could guide or frame the ToR for the Commission, including: public health; service system/s and outcomes; resource allocation; social determinants of mental ill-health; or human rights, to name a few common approaches.

We note also the Government's preference to avoid a 'truth and reconciliation' inquiry, but stress the importance of centralising the voices and experiences of people who have been impacted by current and historical policy and program arrangements as key informants to improving mental health and wellbeing. It is essential therefore to find a framework that is

[1] ABC News, 'Victorian Premier Daniel Andrews promises https://www.abc.net.au/news/2018-10-24/victoria-daniel-andrews-royal-commission-into-mental-health/10423104

[2] Australian Institute of Health and Welfare, Mental Health Services in Australia, 'Expenditure on mental health related services 2015-16' (last updated February 2018), accessible at: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services

sufficiently broad to enable wide and meaningful investigations, testimony and analysis, whilst being limited and precise enough to ensure coherent and meaningful recommendations for systems responses.

To this end, we recommend a human rights approach that anchors the Commission's ToR around the international, national and State human rights obligations that apply to all Victorians. Such a framework would provide sufficient breadth to enable public health analysis, and the synthesis of multidisciplinary qualitative and quantitative evidence, whilst enabling analysis of the myriad social determinants for mental ill-health, and outcomes of policy and programs. Moreover, it would provide a strong rationale for centring people's experiences in a shared roadmap for change.

We believe that a codified human rights framework for the Commission would provide sufficient safeguards and trust to enable meaningful participation of people of lived experience of mental ill-health, as well as their families and carers. A human rights approach to this public inquiry would align with the prevailing recovery and wellbeing model of mental health care, place Victoria as a leader (and innovator) in the conduct of complex public inquiries, and accord with the approach taken by the Government of New Zealand in its recent national inquiry into mental health and addiction[3]. Such an approach would also build on the valuable work of the 1993 *National Inquiry into the Human Rights of People with Mental Illness*[4]

Specifically, we suggest that the Commission's operational framework be defined with reference to:

1.) Applicable State legislation, including the Inquiries Act 2014 and the Charter of Human Rights and Responsibilities Act 2006
2.) International Human Rights Instruments, including:
    a. International Covenant on Civil and Political Rights
    b. International Covenant on Economic, Social and Cultural Rights
    c. Convention on the Rights of Persons with Disabilities

We recommend a framework guided by this combination of legislative instruments, on the basis that the Convention on the Rights of Persons with Disability on its own is too narrow in scope, since mental ill-health does not necessarily imply disability. However, in combination with the two international conventions cited above, these three instruments could work to provide a broad enough framework to cover all known social determinants of mental wellbeing and mental ill-health. This combination of instruments would give a framework to assess what is being done currently, and to guide the design of alternative approaches on what could or should be done.

In practical terms, an inquiry framed by a rights-based approach would include, at a minimum, the following elements:

[3] 'He Ara Oranga', Report of the Government Inquiry into Mental Health and Addiction, November 2018, Annex A at pp. 214 (Principles, ss. 5)
[4] Human Rights and Mental Illness, Report of the National Inquiry into the Human Rights of People with Mental Illness, Human Rights and Equal Opportunity Commission (Australia), Volume 1, 1993. Specific attention should be placed on the 'Terms of Reference at pp.5.

- Inclusion of people from the affected group/s in the **governance of the inquiry**, with involvement in decision-making at all of its phases, including determining its scope
- Processes for **engagement and participation of the affected communities** that have been designed with input from them/their representatives
- Use of the articles in the **human rights conventions and covenants** named above, to frame **the analysis** of the evidence that the inquiry will collect
- Opportunities for 'experts by experience' to scrutinise the evidence and analysis, and processes to ensure that **recommendations are set** with equal input from 'experts by experience' and 'experts by profession'.

With regard to this latter point, we draw the Commission's attention to innovative approaches that have been used elsewhere, such as Citizens' Juries. These have been used successfully in large jurisdiction health service policy design and service development, where evaluation has demonstrated effectiveness and empowerment outcomes to the affected communities.

We recognise that any inquiry will have limitations imposed on it, but consider this to be the most applicable approach to the task in hand, and well aligned to the *Victorian Charter of Human Rights and Responsibilities Act (2006)*. Through this approach, the Commission's consideration of mental health can be scrutinised through a broad yet clearly defined framework, grounded in binding legal instruments that can shape future service and system reforms and responses.

Specific recommendations on process for and scope of the Commission

1. Participation by people with lived experience of mental ill-health

Mind considers it essential that the Commission draws on people's experiences of mental ill-health, service use and non-use, and recovery, and treats the knowledge from this as equal to other ways of knowing. This means ensuring that people with direct experience of mental ill-health and recovery, and their families and carers, have effective and safe ways to share their experiences. It means recognising that this will require having different ways for people to take part, and making sure that processes for participation are co-designed with people with lived experience. It also makes incumbent on the Commission to equally regard and value 'experts by experience' and 'experts by profession', so that their voices, and the knowledge they express, are treated as equal in value. This can only happen when there is express recognition of the ways in which some voices and ways of knowing are privileged, whilst others remain marginalised and treated as less important, less valid and less 'true'.

To ensure the central and equal treatment of knowledge from lived experience, we recommend that the inquiry's processes give due consideration to the need to:

- Have a person with lived experience included at the highest level representation within the choice of Commissioners
- Include the formation of a lived experience expert advisory council, equal to the panel of professional and technical experts. Both panels should operate on occasion separately and on occasion together to inform the direction of the inquiry
- Have clear articulation of principles for arrangements to support authentic participation as part of the ToR, including support for people who want to take part, diverse ways in which people can make input, public and private hearings,

opportunities to take part at different stages throughout the process, provision made for people to take part in languages other than English, including Auslan.

We believe that a **desired outcome** for the Commission is to see lived experience representation on all health service boards, and a funded commitment to co-production and co-design in service development, planning, delivery and review.

2. Treatment of evidence

Significant consideration should be given at this early stage into how the Commission will treat the vast bodies of existing relevant data and evidence from empirical research that already exists, and synthesize these with the 'new' evidence that it will collect or codify. We recommend that, once the ToR have been set, academics and others with appropriate expertise be commissioned to undertake rapid evidence reviews on key topics. Lived experience input into considering the implications of these should be a key part of evidence synthesis. This input should be fully resourced by people with appropriate skills to 'read across' evidence from vastly different ways of knowing about mental illness, mental distress and recovery. These skills include capability in knowledge that is co-produced (i.e. an ability to work with people with lived experience who may not have technical or academic backgrounds, to facilitate their critical appraisal of other forms of evidence).

We note that Mind, through its research program, has some capability in synthesising diverse forms of evidence and in the co-production of new knowledge, and it is likely that other community-managed organisations may also be able to contribute similar expertise.

3. Comments on the proposed categories in the current survey

As part of this consultation process, the Victorian Government has provided an online opportunity for individuals and other stakeholders to rank a non-exhaustive list of ten 'categories' as possible focus areas for the Commission. We do not consider this to be a helpful starting point. The approach currently set out on the Royal Commission website appears to imply a resource allocation framework for the Commission, focused on the existing service delivery architecture in Victoria. This framework implies, as a premise, a zero-sum game in which critical and indivisible components of a complex and fragmented system should be ranked. The non-exhaustive and overlapping nature of these categories means that critical issues that intersect with mental ill-health (including social determinants, stigma and discrimination) may be overlooked.

We are particularly concerned about this, given the overwhelming public response to the survey reported recently in the media. We applaud the government's intention in taking an approach that gives members of the public a say in the early design of the Commission, however we hold a concern about the weight that will be given to a 'survey' that is based on a flawed design. We encourage the Commission to undertake further surveying framed by a human rights approach, and designed by people with appropriate expertise in this type of data collection and analysis.

Further, we are concerned that an approach that seeks to understand priorities in terms of operation of current arrangements may place greater prominence on what needs to happen to 'fix' services and supports at the acute and tertiary end of the service continuum. We contend that, for far too long, the focus of the mental health system has been on the acute end of the system, and the possibilities offered through a strong community-managed sector, peer workforce and peer-led services have not been sufficiently developed. A greater focus on, and investment in, prevention and early intervention, community-managed and peer-led approaches could deliver cost efficiencies and improved outcomes for people.

We highlight the issue of suicide as an area that may be overlooked if the current trend on focusing on acute services continues. As is well established, suicide is a major community issue in Australia. The seven-day period post-discharge from an acute service, or following a presentation to an Emergency Department, is a period of heightened risk of death by suicide, and yet follow-up support to people in the community is inadequate or lacking altogether. We note that simple and effective follow-up interventions do exist, but these are often localised and subject to insecure funding arrangements. Moreover, expanded approaches to follow-up present an excellent opportunity for responses from the community-managed sector, peer workforce and integrated allied health solutions. However, if the ToR focuses too narrowly on what is wrong at the acute end of the service continuum, these opportunities will be overlooked.

4. Determinants and variables that intersect with mental health

Working within a human rights framework, the Commission would be mandated to investigate and analyse the full spectrum of health, social and economic variables that intersect with mental health and ill-health, including economic inequality, poverty, social exclusion, inadequate housing, and forms of violence, including family violence sexual violence and bullying. Historical and contemporary differences in outcomes for the Aboriginal and Torres Strait Islander community must be given explicit attention by the Commission.

We would urge the Victorian Government and the Commission to consider the New Zealand Government's recently published Inquiry into Mental Health and Addiction. The scope of this inquiry included, amongst other things, consideration of:

- *"mental health problems across the full spectrum from mental distress to enduring psychiatric illness…*[and]
- *… activities directly related to mental health and addiction undertaken within the broader health and disability sector (in community, primary and secondary care), as well as the education, justice and social sectors and through the accident compensation and wider workplace relations and safety systems…* [and]
- *… the wider social and economic determinants of mental health and addiction (for example poverty, inadequate housing, family violence or other trauma) and cultural factors, in particular the historical and contemporary differences in outcomes for Māori, and consider the implications of these determinants and factors for the design and delivery of mental health and addiction services".*

In practical terms, there are major issues at the intersection between mental health and housing/homelessness services, juvenile and criminal justice, education and employment. We

encourage the Commission to take an approach that would deliver outcomes in each of these areas.

We note that social determinants of health are not static, and are influenced by changing resources and practices in the wider context, for instance the development, access to and uptake of technologies such as smart phones and other personal devices. The dynamic nature of what determines health and wellbeing across a population at any given time is another reason why the inquiry should give an equal and central place to the voices of people with lived experience of mental ill-health and recovery.

We also note that the scope of Productivity Commission's concurrent inquiry into the social and economic benefits of improving mental health includes consideration of wider social determinants of mental health and systems that support mental wellbeing (in particular: housing; criminal justice; family violence; education; employment). Mind will be making a strong submission to the Productivity Commission on this point, and we are keen to see sufficient breadth to the Victorian inquiry to cover a wide range of social determinants and outcomes.

5. Commonwealth/State arrangements

As noted in the preamble to this submission, 'mental health' is subject to complex arrangements between intersecting and overlapping systems funded and governed at state, federal and local levels. The complexity impacts on individuals, and on the organisations that are funded to provide services to them. We recommend that the ToR explicitly include investigation of current governance arrangements, to understand what is being commissioned:

- downwards through state/commonwealth agreements
- upwards through the Primary Healthcare Networks, and
- laterally via individual funding packages delivered through the NDIS.

This part of the investigation should seek to establish what needs are being addressed through services that are governed at the various different levels, the impact of transitions between contracts, an assessment of their coverage and analysis of likely gaps (for instance, flexible respite and supports for families and carers). It should seek to examine the intersections and extent of integration at three levels: system/policy; program and service delivery; and, for the individual consumer and their families and carer/s. In particular, it should seek to identify points of disruption and discontinuity, since these are equally opportunities for reform and improvement.

We note that the State/Commonwealth interface is not inherently problematic, and recognise that it is an enduring part of the Australian federated model. However, we are concerned to ensure that the experience of seeking, accessing and using services and support is as easy and encompassing as possible for people who need help in order to lead a contributing life. At present, this is not the case (and hence, the high priority placed on the category of 'accessibility and navigating the mental health system' in the current online survey for the Commission).

Consistent with our commentary on the social determinants of mental health in the preceding paragraphs, this part of the inquiry should also seek to understand the opportunities for improved responses for people who need support from multiple systems abutting mental health service delivery systems (for instance, housing/homelessness, juvenile and criminal justice, family violence, education and employment).

We wish to see a set of **desired outcomes** that address problems of integration at these system boundaries. These should cover all three levels of integration: system, service and individual. From 'working at the coalface' with consumers and family members across Victoria, we know that the lack of integration at system and service levels is a major issue with material impacts on people's health and wellbeing. We note the lack of support for people to navigate a maze of promising possibilities, rejections on the basis of eligibility, inaccessible services and other dead ends before they find a way through to what they need, is a major barrier to recovery. We would like to see, as a **specific outcome**, a recommendation on the establishment of a funded service that would combine system navigation (including broader community resources), care co-ordination and coaching to help people build their capacity to 'find their own way'.

6. Stronger focus on recovery as the guiding principle for implementation

Linked to our preference for an inquiry framed by human rights, we recommend a specific reference to recovery in the ToR. Services in Victoria are governed by two excellent frameworks for ensuring a recovery-orientation in service delivery: *Victorian Framework for Recovery-Oriented Practice (2011)*, and *National Framework for Recovery-Oriented Mental Health Services (2013)*. Whilst both documents provide solid scaffolding for service delivery, they are not implemented systematically, and accountability is weak. We would like to see a set of outcomes on strengthening the recovery-orientation of service delivery, with particular focus on the role of people with lived experience in the implementation of services, and on accountability mechanisms to ensure consistent, comprehensive and sustainable practice in all mental health services across Victoria.

In addition, the Victorian Mental Health Act (2014) provides a strong legislative basis for some elements of a recovery-oriented system, most notably human rights, recovery-orientation as a basis for practice, supported decision-making and advance statements. However, we do not believe that these elements of the Act are given sufficient weight in implementation, and we lack strong systems for holding services to account for their practices and performance under the Act. In the interests of Victorians who are subject to its restrictive and coercive powers, a greater balance in implementation between the Act's powers to protect individuals experiencing mental illness and to protect others needs to be achieved.

It is four years since the commencement of the Mental Health Act in July 2014, and we believe this inquiry presents an excellent opportunity to review its implementation against a human right framework.

7. Role of the community-managed sector in a contemporary mental health system

We believe that a **desired outcome** from the inquiry is a set of recommendations on the role of the community-managed sector, the role of peer work, and the future potential for peer-

run services. We would like to see outcomes that cover the role of the community-managed sector in the delivery of a broader range of sub-acute services, and in the delivery of crisis services in the community that would provide an alternative to Emergency Departments and stays in acute inpatient units.

There is a growing body of research evidence to support the case for a strong and vibrant community managed sector, focusing on the forms of support that enable people to lead contributing lives. Likewise, there is substantial evidence on the efficacy of peer work, and people's preferences for peer support. Whilst there is a great deal of lip service paid to peer work, little has been done to codify it in funded service delivery.

Mind strongly advocates for a future role for the community-managed sector that includes services that are currently seen as the province of clinical services, redesigned to place a greater focus on social and economic outcomes for people. We seek recommendations on alternatives to restrictive and costly forms of acute care that can be delivered in the community wholly by community-managed organisations and in partnership with our clinical colleagues. In expressing this hope, we draw on our substantial experience in working in partnership with clinical providers in various forms of sub-acute service delivery. We contend that the strength of these partnerships is one factor in supporting better recovery outcomes for people experiencing mental ill-health, and we encourage the Commission to consider an extended scope for the community-managed sector.

We draw attention to our desire for outcomes on the future of community-managed services in the hope that they can be accommodated in the ToR, thus ensuring attention within the inquiry.

8. Workforce development and retention

Mind strongly supports a focus on workforce as part of the Commission's scope. The comments we make following relate to the community-managed mental health workforce, and to the peer workforce, and contend that these need to be treated as two distinct entities facing shared and distinct challenges.

With reference to the community-managed mental health workforce, we stress the importance of ToR that can examine the implications of current policy, program and funding arrangements on the workforce. Fragmentation, short-term contracting, and commissioning on the basis of 'efficient price' that fails to recognise what goes into the provision of high quality, safe support are combining to drive a trend across the sector to casualisation, job insecurity and employment on minimum qualifications. The nature of the support need has not changed. Burn-out is high, and it is difficult to attract and retain staff in the current conditions. In our view, the situation is now reaching critical levels, and is impacting on service quality and outcomes for individuals. In turn, this impacts on the cost efficiency of the public investment in mental health service delivery. Community mental health practitioners carry a considerable burden of secondary trauma and are at risk of 'compassion fatigue', posing a significant work health and safety risk to organisations and to the workforce as a whole. We note that this component of labour is not recognised in 'efficient price' mechanisms which focus only on what is transacted, and are unable to count the function of the relationship that is so central to good recovery-oriented support, and the emotional labour it involves that they

undertake. This situation compares to the 'efficient price' for other professional categories, such as psychologists, where the therapeutic relationship and emotional labour is taken into account.

We believe that a **desired outcome** for the inquiry is to see recommendations on the need for specialisation in recovery-oriented support and rehabilitation for people with complex mental illness, with commensurate funding. Within the examination of the community-managed mental health workforce, specific attention needs to be paid to regional and rural Victoria, and a focus in the recommendations that will ensure that Victorians living outside metropolitan centres are not disadvantaged.

We are keen that the scope of the Commission also incorporates the role that a strong peer workforce can play in supporting better mental health outcomes. There is now sufficient evidence to demonstrate the efficacy of peer work as a legitimate modality for mental health recovery, but with patchy implementation in Victorian services (clinical and community-managed). We believe that a **desired outcome** for the inquiry is the recommendation that a peer workforce strategy be developed so that peer workers are available in **all** mental health services, and peer-led alternatives are available across all parts of the service continuum from crisis to ongoing supports.

9. Capacity to accommodate input on people's negative experiences of mental health services

If the Commission is to centre the voices of people with lived experience, then it must be prepared to accommodate and respond to negative experiences of health service use, including abuse and harm in services themselves. Mind strongly believes that unless there is space for these experiences to be included, the inquiry will do a disservice to the Victorians who should benefit from this courageous initiative.

10. Intersection with other National Inquiries

The Commission's work will operate in parallel to the Productivity Commission's Inquiry into Mental Health, and the Royal Commission in Aged Care Quality and Safety. Since there is likely overlap in the issues that these processes will consider, the ToR should define a process for how these public inquiries can collaborate with each other.