Australian Parliamentary Study Field Visit (Mental Health)

United Kingdom, Netherlands, Sweden and Canada

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Parliamentary Field Visit

The parliamentary field visit examining mental health policy issues visited England, Holland, Sweden and Canada; this was the second visit of its type by the Australian Parliament. The parliamentary field visit format is designed to allow parliamentarians to explore and examine a particular issue in depth through meetings with dignitaries, officials, non-government Organisations and members of the public, and site visits.

Objectives of the Parliamentary Field Visit

The theme of this parliamentary field visit was to examine mental health practices and policy perspectives in the selected countries. In particular, the delegation was focused on hearing about the different issues and treatment approaches for mental health care services generally, eating disorders, children and early intervention services, young people with mental health issues, and where possible, Indigenous people's mental health issues, suicide broadly and post-traumatic stress disorder among defence veterans. The delegation's aim was to examine, listen and develop an understanding of how the respective countries were approaching mental health issues and what examples or practices could possibly be considered for Australia.

Delegation members, Senator Rachel Siewert, Senator for Western Australia (Delegation Leader), Senator Deborah O'Neill, Senator for New South Wales and Andrew Wallace MP, Member for Fisher, (Qld) outside Westminster Hall at the Houses of Parliament, London, United Kingdom.

While the program included meetings with a range of Government officials, its main focus was visiting health experts, non-government organisations, community leaders, and academics including site visits where possible.

The delegation appreciated the many frank discussions held and views shared during the field visit. Such discussions gave the delegation a thorough appreciation of the range of issues and challenges currently facing mental health globally.

Acknowledgements

The delegation would like to extend its thanks to all of people with whom it met and who generously gave of their time and expertise. During meetings and site visits the delegation was accompanied by officers of the Department of Foreign Affairs and Trade (DFAT) stationed in each of the countries. The professionalism, knowledge and guidance of these officers were very much appreciated. The delegation extends its particular thanks to:

England—London:

- High Commissioner H.E. the Hon Alexander Downer
- Deputy High Commissioner, Mr Matt Anderson
- Mr Duncan Howitt, Political Officer

Netherlands—Amsterdam and The Hague:

- High Commissioner H.E. Dr Brett Mason.
- Ms Maaike den Besten, Consular & Public Diplomacy Officer

Sweden—Stockholm:

- High Commissioner H.E. Mr Johnathon Keena, Ambassador to Sweden
- Mr Antony Lynch, Second Secretary,
- Ms Susanna Fridlund, Public Diplomacy and Research Officer

Canada—Ottawa:

- High Commissioner H.E. Mr Tony Negus AO APM
- Mr Andrew Clarke, Chief Research Officer and Economic Diplomacy Officer
- Ms Brittany Noakes, Second Secretary, Embassy of Australia

The delegation also wishes to thank the other embassy staff, drivers and security personnel who assisted with the field visit. Photographs in this report are provided courtesy of the delegation members and the delegation secretary.

Introduction

International mental health policy framework

The United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care

In December 1991, the United Nations General Assembly passed a Resolution to adopt the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* put forward by the United Nations Human Rights Commission. The Australian Human Rights and Equal Opportunity Commission, together with the Australian Government, played a major role in drafting of these Principles.[1]

World Health Organisation and OECD reports

Ten years later, in 2001, the World Health Organisation (WHO) released its seminal report, *Mental Health: New Understanding, New Hope,* with its startling prediction that 'one in four people internationally would be affected by a mental or neurological disorder in their lives'.[2] With greater understanding of the effects and causes of mental ill health, the OECD later published two further major analyses on mental health; in 2012, *Sick on the Job, Myths and Realities about Mental Health and Work,*[3] and in 2015, *Fit Mind, Fit Job, from evidence to practice in Mental Health and Work.* A key conclusion of the analysis stated that 'a transformation was required in policy thinking about mental health'.[4] Above all the paper sets out key elements to an integrated policy approach to promote better mental health and employment outcomes, and includes policy examples of intervention in education, employment, health and welfare to assist countries develop future mental health strategies.

WHO Mental Health Action Plan 2013–2020

In May 2013, the 66th World Health Assembly adopted the *WHO Mental Health Action Plan 2013-2020*, perhaps the most influential of policy documents regarding mental health and constructing effective mental health strategies. The Action Plan recognises the importance of encompassing mental health into any general health dialogue:

> Mental well-being is a fundamental component of WHO's definition of health. Good mental health enables people to realize their potential, cope with the normal stresses of life, work productively and contribute to their communities.[5]

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1 United Nations General Assembly, A/RES/46/119, 75th plenary meeting, 17 December 1991, http://www.un.org/documents/ga/res/46/a46r119.htm

2 The World Health Organization, The World health report: 2001: Mental health: new understanding, new hope, p. 2. http://www.who.int/whr/2001/en/whr01_djmessage_en.pdf

3 OECD.org, 2012, Sick on the Job, Myths and Realities about Mental Health and Work, https://www.keepeek.com//Digital-Asset-Management/oecd/social-issues-migration-health/mental-health-and-work_9789264124523-en#page4, p. 4.

4 OECD.org, 2015, Fit Mind, Fit Job, from evidence to practice in Mental Health and Work, https://www.keepeek.com//Digital-Asset-Management/oecd/employment/fit-mind-fit-job_9789264228283-en#.WqDQ72lubmE#page5, p. 3.

5 The World Health Organization, Mental Health Action Plan 2013-2020, May 2013, http://www.who.int/mental_health/publications/action_plan/en/, p. 5.

The Action Plan is based on a life-course approach and aims to achieve equity through universal health coverage and stresses the importance of prevention and intervention. The four major objectives of the Action Plan are to:

- strengthen effective leadership and governance for mental health.
- provide comprehensive, integrated and responsive mental health and social care services in community-based settings.
- implement strategies for promotion and prevention in mental health.
- strengthen information systems, evidence and research for mental health.[6]

Each of the four objectives has one or two specific targets, which provide the basis for measurable collective action towards global WHO goals. A set of core indicators relating to these targets and other actions have been developed and will continue to be collected via the WHO Mental Health Atlas project[7] on a periodic basis.

However, the Plan highlights that there is a long way to go to achieve equity. Specifically the Action Plan notes that, 'many unfortunate trends must be reversed—neglect of mental health services and care, and abuses of human rights and discrimination against people with mental disorders and psychosocial disabilities.[8]'

The collective works of the OECD and WHO with reporting against the UN's key principles have helped elevate mental health firmly within the mainstream of national health policies. More recently, international focus has been directed at how services are provided within finite budgets with increasing emphasis on how to exact better quality and value for those services, as well as better services for patients.

Australian national mental health policies and strategies

The importance of good mental health and its impact on Australians has long been recognised by Australian governments. Over the last three decades, governments have worked together via the National Mental Health Strategy to develop mental health programs and services to better address the mental health needs of Australians. The National Mental Health Strategy has included four 5-year National Mental Health Plans covering the period 1993 to 2014, with the Council of Australian Governments (COAG) National Action Plan on Mental Health overlapping between 2006 and 2011.

In December 2016, the Commission Chair for Australia's National Mental Health Commission (NMHC), Professor Alan Fels AO, stated that the estimated annual cost of mental ill-health in Australia is around four per cent of GDP or about $4000 for every tax payer, costing the nation more than $60 billion. As such, improving mental health is an invest-to-save issue. Professor Fels stated that 'there is a need for action across sectors to improve our mental health system through appropriate allocation of resources and to build the

6 The World Health Organization, Mental Health Action Plan 2013-2020, May 2013, http://www.who.int/mental_health/publications/action_plan/en/

7 The WHO Mental Health Atlas Project is designed to collect, compile and disseminate data on mental health resources worldwide. Resources include mental health policies, plans, financing, care delivery, human resources, medicines, and information systems.

8 The World Health Organization, Mental Health Action Plan 2013-2020, May 2013, http://www.who.int/mental_health/publications/action_plan/en/, p. 05.

mental health of our nation and as such the Commission has put the impact of poor mental health firmly on the economic agenda.'

In particular, Professor Fels noted that:

> Evidence suggests we should focus on prevention and early intervention which can reduce the need for more complex and costly interventions. Our current focus is on treating mental illness once it hits crisis point, whereas preventative interventions can improve peoples' lives and are cost effective. These interventions can involve improving health treatments as well as areas such as disability, housing and employment services.

The *2017 National Report on Mental Health and Suicide Prevention* also notes that 'investing in mental health is not only morally and socially compelling, it is economically fundamental. Mental illness has significant personal impacts and broader implications for the Australian economy.'[9]

Countries visited

The chief aim of the delegation's visit was to examine a range of mental health issues and practices together with the policy perspectives of leading internationally recognised health practitioners and institutions. As is often the case with Parliamentary delegations, opportunity to visit in-country experts is constrained by time and geography. In this case the delegation was limited to central cities in each of the following countries; London, England; Amsterdam and The Hague, Netherlands; Stockholm, Sweden; and Ottawa, Canada.

Table 1. Countries visited–General comparative statistics 2016

	Australia	United Kingdom	Sweden	Netherlands	Canada
Population (million)	23.78	64.88	9.75	16.90	35.85
% of GDP Healthcare spending, (2016)	9.6%	9.7%	11.0%	10.5%	10.6%
Health Care Spending (per capita) Provisional data	$4,708	$4,192	$5,488	$5, 385	$4,753
Annual average growth in per capita expenditure, real terms, (2009-2016)	2.7%	0.9%	0.9%	1.0%	1.1%
Out-of-Pocket Health Care Spending (per capita)	$532	$586	$787	$649	$644
Spending on Pharmaceuticals (per capita)	$626	$485	$489	$401	$772

Source: Compiled by the Commonwealth Fund 2016, using OECD 2016 data. All figures are in USD converted from local currency using the purchasing power parity conversion rate for GDP in 2015 reported by the Organisation for Economic Co-operation and Development (2016). Note that some of the in-country expenditure figures can differ slightly.

In all, the delegation undertook 35 separate meetings across four countries.[10] The delegation chose the countries it visited based on the international reputation of work being undertaken in one or more of the following areas:

9 2017 National Report on Mental Health and Suicide Prevention, p. 52.

10 Appendix A, provides a list of the individuals and institutions the delegation met with.

- Provision of mental health services
- Children and young people and mental health issues – early intervention services
- Eating disorders and anorexia – in and out patient care approaches
- Suicide–particularly in young people and indigenous communities
- Indigenous mental health
- Post-traumatic stress disorder (PTSD) among veterans and first responder emergency personnel
- Mental health generally, including innovative delivery solutions

United Kingdom

In the United Kingdom (UK), the delegation met with London-based researchers, specialists and practitioners.

United Kingdom Health System

The UK has a universal national health service (NHS) that covers all permanent residents with free access to service that is paid for by general taxation (with some employment related insurance contributions). In 2016, the UK spent 9.7 per cent of GDP (£138.5 billion) on its health care system, of which 86 per cent was spent on the NHS.[11]

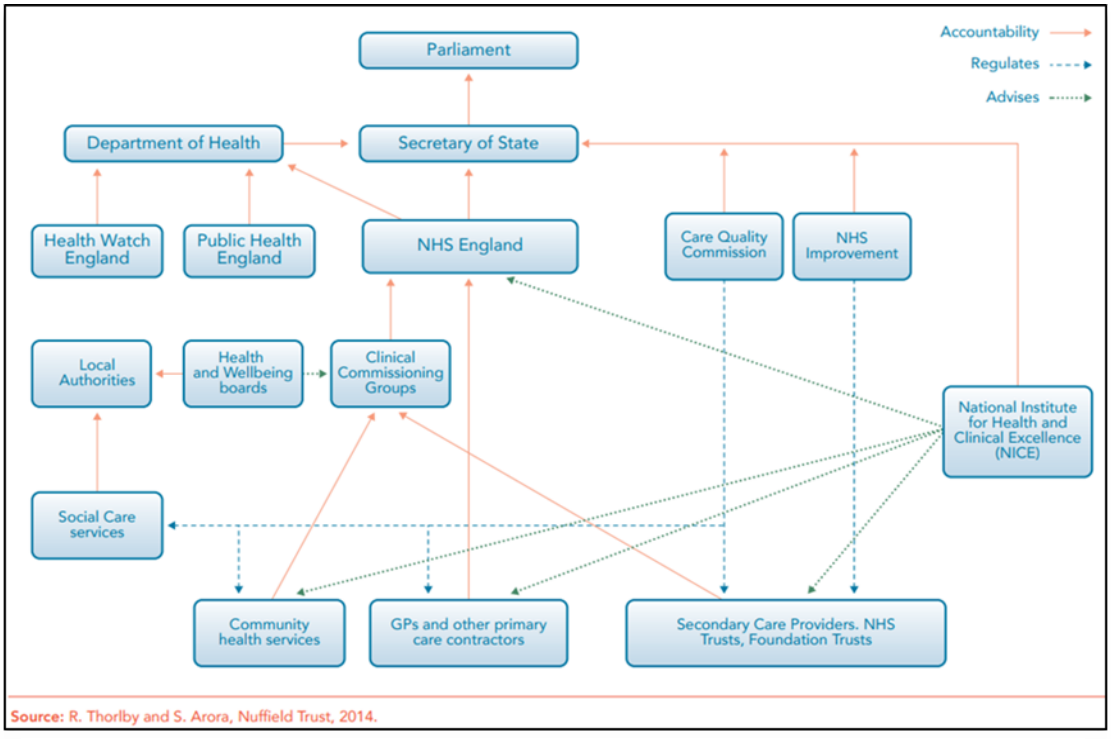

Diagram 1.Structure of the UK NHS health system

While the NHS is classed as a 'national' system, it is in fact four separate systems independently managed: The National Health Services (NHS England), NHS Wales, NHS Scotland and Social Care in Northern Ireland. In recent years there has been considerable

11 2017 International Profiles of Health Care Systems, The Commonwealth Fund, p.49. and NHS Confederation, http://www.nhsconfed.org/resources/key-statistics-on-the-nhs

devolution of health care and public health powers to the jurisdictions. Patients who are legal residents of the UK may use the services in any of the four jurisdictions–if a patient requires specialised care that is not locally available there are no issues in sending them across internal country borders.

Tuesday 26 September 2017

Delegation meetings

Royal College of Psychiatrists

Dr Jon Goldin, Consultant Child and Adolescent Psychiatrist, from the Royal College of Psychiatrists (RCPsych), Holly Taggart the RCPsych, Head of Policy and Campaigns, and Ms Zoe Mulliez, Policy and Campaigns Officer

The first meeting for the delegation in London was with representatives from the Royal College of Psychiatrists who provided a comprehensive overview of the UK health and mental health system including some of the present reforms and challenges.

The delegation learnt that the UK has a universal national health service (NHS) that covers all permanent residents with free access at point of use. The service has been largely characterised as a 'top down' structure, centrally controlled from a large district general hospital linked in with relationships with hospital consultants and to general practitioners.

Parity of Esteem

Since 2011, a key tenet for mental health, unique to the UK health system and enshrined in its *Health and Social Care Act 2012*, is the notion of 'parity of esteem'. The 2014–15 NHS Mandate states that, "NHS England's objective, is to put mental health on a par with physical health" which is defined as 'valuing mental health equally with physical health'. [12] Doing this would result in those with mental health problems benefitting from:

- equal access to the most effective and safest care and treatment
- equal efforts to improve the quality of care
- the allocation of time, effort and resources on a basis commensurate with need
- equal status within healthcare education and practice
- equally high aspirations for service users
- equal status in the measurement of health outcomes.

UK Five Year Forward View–new models of healthcare provision

Since the introduction in 2014 of the NHS' *Five Year Forward View* (Forward View) strategic plan, the delegation heard that the UK has embarked on a radical restructure and rethink of its provision of care services. The Forward View notes that a 'radical upgrade in prevention and public health' was needed to adapt to a changing world and there are new ways for doing things:

> Our values haven't changed, but our world has. So the NHS needs to adapt to take advantage of the opportunities that science and technology offer patients, carers and those who serve them. But it also needs to evolve to

12 The House of Commons, The Government mandate to NHS England for 2017-18:Written statement - HCWS547, https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2017-03-21/HCWS547/

> meet new challenges: we live longer, with complex health issues, sometimes of our own making. One in five adults still smoke. A third of us drink too much alcohol. Just under two thirds of us are overweight or obese.
>
> These changes mean that we need to take a longer view—a Five-Year Forward View—to consider the possible futures on offer, and the choices that we face. So this Forward View sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health.[13]

UK Mental Health Taskforce

Alongside the Forward View, the delegation heard that an equivalent five year 'forward view' for mental health was produced by a Mental Health Taskforce in 2016. Like many other international counterparts, the report advocates the need for far more proactive early intervention and preventative action in regard to mental illness to reduce the long term impact to the individual and the broader economy.[14]

Presently, the UK estimates the cost of mental health related issues to the economy (the largest single cause of disability in the UK) is £105 billion a year.[15] The *Five Year Forward View for Mental Health* report highlights some sobering statistics:

- one in four adults experiences at least one diagnosable mental health problem in any given year;
- one in ten children aged 5-6 has a diagnosable problem;
- one in five mothers suffer from depression, anxiety or in some cases psychosis during pregnancy or in the first year following child birth (this noted that 30,000 women accessed some form of specialist mental health care during the perinatal period);
- one in five older people living in the community and 40 per cent in care facilities are affected by depression;
- people with long term physical illnesses suffer more complications if they also develop mental health problems;
- people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people;
- only half of veterans of the armed forces experiencing mental health problems like Post Traumatic Stress Disorder seek help;
- suicide is on the rise. While the rise is highest amongst middle aged men—it is the leading cause of death for men aged 15-49. Men are three times more likely than women to take their own lives, they accounted for four out of five suicides in 2013;
- stable employment and housing are both factors contributing to someone being able to maintain good mental health and are important outcomes for their recovery if they have developed a mental health problem;

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13 NHS, Five Year Forward View, October 2014, https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf, p. 2.

14 UK Mental Health Taskforce, https://www.england.nhs.uk/mental-health/taskforce/

15 *Five Year Forward View For Mental Health*, A report from the independent Mental Health Taskforce to the NHS in England, February 2016, p. 4.

- people in marginalised groups are at greater risk, and
- nine out of ten people in prison have a mental health, drug or alcohol problem.[16]

Five Year Forward View for Mental Health

In February 2016, the Mental Health Taskforce published its *Five Year Forward View for Mental Health* which set out the state of mental health service provision in the UK and proposed 58 recommendations for UK mental health care.

The delegation heard that NHS England and the UK government accepted all of the Taskforce's recommendations in February 2017, and agreed that mental health services would receive an additional investment of £1billion per year by 2020/21.

Among the key deliverables in the first stages of the implementation of the five year plan are new access and waiting times for psychological therapies and early intervention in psychosis. These came into force from April 2016. Eating disorder services for young people followed in 2017.

The delegation understands that the immediate priorities for service redesign are:

- to increase access to specialist perinatal care;
- reduce the number of out-of-area placements for children, young people and adults through the provision of more care closer to and at home (out patients);
- to increase access to crisis care liaison services in emergency departments and inpatient wards; and
- suicide prevention.[17]

New care models—Accountable Care Organisations, Integration of services and local government provision of services

The delegation heard that central to the new approach outlined in the *Forward View* is the recognition that services are diverse and 'one size no longer fits all'. The NHS restructure has focused efforts on creating 'new care models', initially referred to as Accountable Care Organisations (ACO), that are analogous to the accountable care systems introduced in President Obama's health reforms. Accountable care systems, the delegation was told, are focused to concentrate on building greater linkages and partnerships at a local level through integration and co-location of community-based multidisciplinary teams, co-ordinated around clusters of GP practices and serving populations of 30,000 to 50,000 people.

The Kings Fund[18] notes that 'new care models' 'mark a shift away from policies that have encouraged competition towards an approach that relies on collaboration between the different organisations delivering care'. The emphasis is now placed on populations and systems rather than organisations. More recently, the NHS has changed its terminology from accountable care systems (ACS) to 'integrated care systems' (ICS), primarily to counteract

16 Five Year Forward View For Mental Health, A report from the independent Mental Health Taskforce to the NHS in England, February 2016, p. 4.

17 https://www.england.nhs.uk/mental-health/taskforce/imp/

18 The Kings Fund is an independent charity working to improve health and care in England that undertake research and analysis of health and social care in the UK. https://www.kingsfund.org.uk/about-us

negative inferences that ACOs 'could result in health and care services coming under the control of private companies.' The NHS has made emphatic statements that:

> If ACOs are established in the NHS, they will be a means of delivering care and not funding it. The principles of a universal and comprehensive NHS funded through taxation and available on the basis of need and not ability to pay will not be affected.[19]

As such, the delegation understands the NHS has developed two main 'new care models' to better meet the changing needs of the populations:

- **Multispecialty Community Providers** (MCPs)—groups of GPs combining with nurses, and other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care; and
- **Provider and Acute Care Systems** (PACs)—which involve integrating primary care and hospital care into single providers—combining for the first time general practice and hospital services into localised healthcare providers, similar to the United States' Accountable Care Organisations.[20]

The delegation noted that since the *Forward View's* implementation, the UK government has also sought to develop new care models through five year Sustainable Transformation Plans (STPs) and ST Partnerships, including selecting 'Vanguard' providers[21] and sites to develop place-based plans for the future of health, mental health and care services in their local area. 'The plans are required to cover all aspects of NHS spending, as well as focusing on better integration with mental health, and importantly with social care and other local authority services and the community at large. They are required to be long term, from October 2016 to March 2021.'[22]

The 2017 report on *Mental health and the new models of care, lessons from the vanguards,*[23] notes that the new care models 'create an important opportunity to deliver whole-person care that responds to mental health, physical health and social needs together—the determinates for population health. The report states that 'developing more integrated approaches of mental health should be a key priority given the close links between mental health and physical health outcomes, and the impact these have on the quality and costs of care.'

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19 The King's Fund, https://www.kingsfund.org.uk/publications/making-sense-integrated-care-systems#acos

20 The King's Fund, https://www.kingsfund.org.uk/publications/making-sense-integrated-care-systems#acos

21 There are 50 vanguard sites in England, each examining different ways of improving and integrating services in their local area. Once evaluated, the most successful models will act as a blueprint for other parts of the NHS, http://www.rcpsych.ac.uk/policyandparliamentary/mentalhealthinthevanguards.aspx,

22 King's Fund, https://www.kingsfund.org.uk/topics/integrated-care/sustainability-transformation-plans-explained

23 The King's Fund and the Royal College of Psychiatrists, May 2017, Mental health and the new models of care, lessons from the vanguards, pp. 3-4. http://www.rcpsych.ac.uk/pdf/MH_new_models_care_Kings_Fund_May_2017.pdf

Dr Jon Goldin and his team highlighted some key issues going forward for mental health in the UK, specifically:

- Drug and alcohol abuse prevention;
- More training for mental health professionals;
- Suicide data and prevention strategies; and
- More treatment for eating disorders.

Value-based care

Noting the objectives articulated by the World Health Organisation's Mental Health Action Plan in influencing national mental health strategies, it's also worth commenting at this point on where another significant direction encapsulated in the UK's NHS Five year plans has been derived.

In 2006, Harvard Business School Professor Michael Porter published his research paper *Redefining healthcare systems*, advocating a value-based healthcare system as the logical solution to many struggling global health systems.

Professor Porter believes that value-based healthcare must be:

> …maximizing value for patients: that is, achieving the best outcomes at the lowest cost. We must move away from a supply-driven health care system organized around what physicians do and toward a patient-centred system organized around what patients need. We must shift the focus from the volume and profitability of services provided—physician visits, hospitalizations, procedures, and tests—to the patient outcomes achieved. And we must replace today's fragmented system, in which every local provider offers a full range of services, with a system in which services for particular medical conditions are in health-delivery organizations and in the right locations to deliver high-value care.[24]

While this patient-centred approach significantly influenced the Obama Healthcare policy, it has also been very influential in much of the UK government's Five year plan. Nevertheless, UK observers are keen to point out that there is a difference in the level of implementation.

A recent UK Economist's report on value-based healthcare notes that British health policy experts see UK value-based healthcare differing from Porter's definition of "maximises value at the lowest cost" particularly in the fact that it is placed in a system that allocates public funds and is committed to providing a service that is free at point of delivery. The British experts believe that it functions on three levels: at the level of patient (personalised value), intervention (technical value) and population (allocative value).

> …The key distinction we would have to make between the Porterian model and what we mean in the NHS is that Porter’s definition of value is patient outcomes over cost, which we would say is necessary but not sufficient for a universal healthcare system…

24 M. Porter (2013). *The strategy that will fix health care*, Harvard Business Review, https://hbr.org/2013/10/the-strategy-that-will-fix-health-care

> …There are two constraints within universal healthcare systems: Number one is a commitment to provide care for the entire population. Number two, is to do so within a finite budget. Neither of those constraints exist within the US system and are not addressed in Porter's model, which does not address population-level outcomes. [25]

Institute of Psychiatry, Psychology & Neuroscience, King's College London

While at King's Institute of Psychiatry, the delegation met with a number of researchers and practitioners throughout the afternoon.

Dr Andre Danese, Senior Lecturer, MRC Social, Genetic, and Developmental Psychobiology and Psychiatry (SGDP) Centre

Dr Danese discussed a range of areas that he is presently examining with the delegation. In particular, Dr Danese spoke about his focus on treating childhood trauma and understanding its consequences, the biological mechanisms through which childhood trauma affects health, resilience, the reversibility of trauma, and possible treatment options.

Dr Danese stated that most children and young people experience at least one traumatic event before age of 18 years. The UK Mental Health Taskforce noted that 'one in ten children aged 5-6 has a diagnosable problem.'[26] A sizeable minority of children exposed to trauma will develop symptoms including re-living of the trauma, developing avoidance strategies, and physiological hyper-arousal. Dr Danese told the delegation that unlike a lot of mental health conditions, Post-Traumatic Stress Disorder (PTSD) has a very early onset because it follows soon after exposure to a traumatic event. A diagnosis of PTSD is usually made when these symptoms persist for more than one month after trauma and they are impairing the individual. For this reason, there is a need to develop interventions that could prevent the onset of PTSD by intervening very soon after exposure to a traumatic event. Dr Danese noted that developing effective early interventions has not been straightforward. It is important to identify and treat PTSD early as many children fail to recover from the symptoms without treatment.

Dr Danese stated that Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) is the treatment with the strongest evidence base for treating children and is often effective. TF-CBT is a specialist form of CBT that includes treatments such as: psychoeducation, which means providing greater information and detail about an individual's condition and treatment options regarding PTSD. Dr Danese told the delegation that Eye Movement Desensitisation and Reprocessing (EMDR) can also be helpful in the treatment of PTSD. However, at present there is no clear evidence to support use of medications for treatment of PTSD in children, but some medications may be very helpful to treat other psychiatric problems (e.g., depression, anxiety) that often accompany PTSD. Treating adolescent children with cognitive behavioural interventions is also an area of therapy that Dr Danese spoke about specifically in regard to assisting adolescents to regulate and 'normalise' their emotions. There is evidence that for mental health problems other than PTSD, online and computerised CBT approaches can work well for young people.

An exciting challenge Dr Danese said, is to develop therapist supported online trauma focused therapy for children and adolescents with PTSD. The benefits of such a system is that

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25 The Economist, Intelligence Unit, Value-based Healthcare: A Global Assessment, http://vbhcglobalassessment.eiu.com/the-uk-value-based-strategy-in-a-changing-nhs/

26 UK Mental Health Taskforce, https://www.england.nhs.uk/mental-health/taskforce/

a condition can be monitored and measured providing diagnosis gaps for future work, and also this enabling a prevalence and population assessment to be undertaken for specific risks.

Dr Danese told the delegation that from his perspective, investing in adequate crisis training and developing and supporting child psychology career progression will be critical in being able to address future needs in the sector.

Professor Louise Howard, Head of the Section of Women's Mental Health

Later in the afternoon the delegation met with Professor Louise Howard, NIHR Research Professor, Head of the Section of Women's Mental Health at King's College.

Professor Howard told the delegation that as part of the *Five Year Forward View for Mental Health* there will be increased access supported for specialist perinatal health care across England. The UK government has begun a phased, five-year programme, investing £365m to build capacity and capability in specialist perinatal mental health services; this is primarily focused on improving access to and experience of care, early diagnosis and intervention, and greater transparency of services in perinatal health.

The perinatal period refers to pregnancy and the first 12 months after childbirth. Perinatal mental health problems while caused during this period can have long-standing effects on children's' emotional, social and cognitive development'.[27] The increased funding was largely brought about after the UK Mental Health Taskforce recommended a funding increase based on the findings of the 2014 London School of Economics (LSE) report, *The Costs Of Perinatal Mental Health Problems* report commissioned by the UK Maternal Mental Health Alliance. The report had identified a range of significant perinatal issues that required urgent attention, including that:

> [O]ne in five [20%] mothers suffer from depression, anxiety or in some cases psychosis during pregnancy or in the first year following child birth (this noted that 30,000 women accessed some form of specialist mental health care during the perinatal period). [28]

Perinatal mental health illnesses can include antenatal and postnatal depression, obsessive compulsive disorder, PTSD and postpartum psychosis. The report noted that these conditions often develop suddenly and range from mild to extremely severe, requiring different kinds of care or treatment. If left untreated, it can have significant and long lasting effects on the woman and her family. It is also one of the leading causes of death for mothers during pregnancy and the year after birth.

Professor Howard informed the delegation, that following on from the *Five Year Forward View for Mental Health*, policy initiatives were being progressed to transform perinatal mental health care designed to address inequalities in access and experience of mental health services. Professor Howard spoke about the LSE study which found that 'depression, anxiety and psychosis carry a total long-term cost to the society of about £8.1 billion for each one-year cohort of births in the UK'. Of this indirect cost, the report showed that perinatal mental illness directly costs the NHS approximately £1.2 billion for each annual cohort of

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27 https://www.england.nhs.uk/mental-health/perinatal/

28 Annette Bauer, Michael Parsonage, Martin Knapp, Valentina Iemmi and Bayo Adelaja, The costs of perinatal mental health problems, London School of Economics (LSE) & Centre for Mental Health, October 2014, p. 3.

births. Prevention and education before and during pregnancy would significantly impact this figure.

Further mothers with severe forms of mental illness admitted into mother and baby units, are apparently at a high risk of losing their newly born child into care. In one example from the report, it was noted that in one unit 'less than 50 per cent of mothers were discharged together with their newborn and at follow-up less than a third of mothers were still with their child'.[29]

Professor Howard noted some of the improvements for the future. These include investment in 5,000 more midwives, (currently in training), and 4,200 more health visitors, together with arrangements for improved training in perinatal mental health for these staff and also for doctors in postgraduate training.

Consistent with many of the findings related to provision of health and mental health services in the UK, Professor Howard supported the development and implementation of community and in-patient multidisciplinary teams which have strong links with maternity services, health visiting, primary care and social care.

Dr Bernadka Dubicka, Chair of Child and Adolescent Faculty, Royal College of Psychiatrists

Dr Dubicka, an expert in working with children and young people, explained that 'young people are still waiting too long for the right help at the right time, and that there is a desperate need to listen more to young people and to provide the right services early on. Dr Dubicka stated that there was also a need for greater resourcing in child mental health in the UK, a lack of social care across all systems is affecting young people. Dr Dubicka spoke about the 2015 Children and Young People's Mental Health and Wellbeing Taskforce *Future in Mind* report which outlined how the UK intends transforming the way Child and Adolescent Mental Health Services (CAMHS) services are delivered.[30] The report detailed how the UK will tackle the challenges to create a system that brings together the potential of the internet, schools, social care, the NHS, the voluntary sector, parents and young people.

Dr Dubicka stated that the report has five key themes:

- Promoting resilience, prevention and early intervention
- Improving access to effective support
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

Dr Dubicka mentioned that as part of this initiative, each NHS Clinical Commissioning Group has to develop a local transformation plan that outlines a whole system transformation of their local services that contribute to, and support children and young people's mental health and wellbeing. The aim of the plans are to change how care is delivered, building it around the needs of children, young people and their families. Dr Dubicka said that there needs to be an interdisciplinary approach (e.g., education, health, police and social care).

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29 Annette Bauer, Michael Parsonage, Martin Knapp, Valentina Iemmi and Bayo Adelaja, The costs of perinatal mental health problems, London School of Economics (LSE) & Centre for Mental Health, October 2014, p. 19.

30 UK Children and Young People's Mental Health and Wellbeing Taskforce, 2015, *Future in Mind*, http://camhs.rdash.nhs.uk/resources/future-in-mind/

Also, more needs to be done in terms of training and developing career pathways for staff to help ensure that communities of professional are established.

King's College and South London and Maudsley NHS Foundation Trust

The delegation met with Dr Mathew Patrick CEO and Mr Gus Heafield CFO of the South London and Maudsley (SLaM) NHS Foundation Trust. Dr Mathew Patrick had recently returned to take up the position at SLaM after working for several years in Australia. Dr Patrick described the changes that were taking place in and around SLaM which epitomised the new direction the UK government and the NHS was having on health services, particularly at the local community level.

Much of the delegation's time in London was spent visiting practitioners at King's College (King's) and the Maudsley Hospital (the Maudsley). King's is a public research university and includes one of London's busiest teaching hospitals. King's has five campuses along with several different medical research faculties including the Institute of Psychiatry. The Maudsley, which sits alongside King's Denmark Hill campus, is one of the oldest dedicated mental health teaching institutions in the UK, initially opening as a military hospital in 1915 and then as a psychiatric hospital in 1923. Both Kings and the Maudsley Hospitals operate as part of King's Health Partners (KHP), an Academic Health Sciences Centre with Guy's and St Thomas' hospitals. The Maudsley is also part of the South London and Maudsley NHS Foundation Trust, (SLaM) with two other psychiatric hospitals, the Bethlem Royal Hospital and Lambeth Hospital, all of which specialise in mental health.

Dr Patrick told the delegation that much is being driven by the NHS' *Five Year Forward View for Mental Health* and the implementation of the NHS' New Care Models. This has increased the push to change how care is delivered while ensuring the quality services and managing costs downwards. For SLaM, and its partnership in the KHP, much emphasis has been placed on developing programmes to integrate mental and physical health, value-based care systems together with integrated healthcare across primary, secondary and social care. As part of this agenda SLaM is focusing on six specialties where they have considerable expertise: education and clinical care with cancer, child health, cardiac, diabetes and obesity, mental health and neurosciences, and regenerative medicine and transplantation. A central element, is the changed focus of services and users, shifting from the reactive to proactive and prevention. Embedded within this move is the new emphasis on social models of population health and wellbeing with greater integration of care.

SlaM describes this approach:

> We believe we can best improve the lives of the people and communities we serve and promote mental health and wellbeing for all by focusing on the development and delivery of population-based mental health solutions.[31]…This means improving outcomes that matter to patients,

31 Population Health was initially referred to by the researchers David Kindig and Greg Stoddart in 2003 and defined it as "the health outcome of a group of individuals, including the distribution of such outcomes within the group." However more recent work often describes it as referring broadly to the distribution of health outcomes within a population, the range of personal, social, economic, and environmental factors that influence the distribution of health outcomes, and the policies and interventions that affect those factors. See, https://www.cdc.gov/pophealthtraining/whatis.html.

> enhancing patient and staff experiences and delivering better health prevention and promotion goals for every pound spent.[32]

In line with the government's MCPs and PACs (see p.13), Dr Patrick explained that a key part of this new framework will see:

- care and support moving out of hospitals and towards primary care, communities and ultimately home;
- hospitals organising around specialist services, including a reformulation of acute admission as a specialist intervention at the top of the care pathway;
- moving from prescription to partnership, in working with citizens and patients, facilitating self-management and peer support with a greater emphasis on helping people to stay well supported by greater use of digital solutions;
- recognising the development of resilient and health promoting communities as key ingredients for real population health; working towards holistic approaches that bridge the mind-body divide that we have artificially created; and
- employ integration and partnership as the primary modes of operation in creating sustainable health economies.

Southwark Wellbeing Hub, Together for Mental Wellbeing

The delegation was particularly keen to see an example of an integrated local service and peer support operating and was very fortunate to be able visit the Southwark Wellbeing Hub.

Delegation meeting with Mr Leon White and Colin Jones at the Southwark Wellbeing Hub.

32 South London and Maudsley (SLaM) NHS Foundation Trust, Annual Report and Summary Accounts 2016/2017, p. 14.

Case Study—Southwark Wellbeing Hub – Integrated community outreach service

What is the Hub and how does it help?

The Southwark Wellbeing Hub is an integrated community based mental health peer support and drop-in centre.

The centre is part of the *Together for Mental Wellbeing* charity which is commissioned and funded by the NHS Southwark Clinical Commissioning Group and Southwark Council.

Integrated care units puts the community at the centre, it envisages communities, health and social care professionals being supported to work better together to provide pro-active and preventative care that gives local people control of their own health and wellbeing. The community is also fully involved in the development of integrated care, providing feedback and input about their experience of services and providing ideas on how they might be improved.

The Hub provides a range of services:

- **Information:** about what organisations, services and activities are available in the community, as well as information and tools to help manage individuals own wellbeing.
- **Navigation:** assist individuals find their way around local services and opportunities, and understand how to get the most from them.
- **Wellbeing Workshops:** The Hub offers a programme of free workshops to provide a range of information on mental health conditions which can help individuals to develop skills and tools to improve their health and wellbeing.
- **Support:** provides practical support for individuals struggling with day-to-day things like debt, a tenancy, benefits, or loneliness. Assist by discussing individual's goals and aspirations and how the Hub can help achieve them by helping put people in touch with local services and even accompanying them to appointments to provide support.
- **Peer Support:** Peer Supporters use their own experiences of mental distress to support others towards better wellbeing on a one-to-one basis. All Peer Supporters at the Southwark Wellbeing Hub are volunteers and receive comprehensive training prior to providing support. We also offer group Peer Support through our Self-Management Groups, which focus on coping strategies, managing wellbeing and setting goals.
- **Online support:** You can also download an information sheet about our services.

Mr Leon White, Southwark Hub Project Manager told the delegation that it provides free and open services to anyone who lives in the area or is registered with a Southwark GP. The centre works on the premise that people who are worried about their mental health often find it difficult to know where to start to address the support services they require.

Mr White explained that the Hub helps take the stress out of finding, choosing and receiving and maximising the necessary support available. Often people feel like there are too many options to choose from and it can be difficult to know exactly what kind of support you might need, where to find it, and how to go about accessing it.

People don't need an appointment for the Hub, it is designed to be flexible and work around clients. People can drop-in or alternatively visit pop-up services within the community, or professionals and support worker can come and meet people at a place to suit them. Support can be provided over the phone or by email. The Hub also offers one-on-one and group support depending on what individuals prefer.

Wednesday 27 September 2017

Post Traumatic Stress Disorder and Mental health in serving personnel

The delegation was keen to visit and discuss experiences with researchers and practitioners regarding Post Traumatic Stress Disorder (PTSD) among military veterans and first responder emergency personnel. During the delegation's visits it met with defence force representatives in the UK, Netherlands, Sweden and Canada, discussing what and how each were examining and dealing with mental health issues in their serving personnel both past and present. The delegation also met with Professor Sir Simon Wessely, Co-Director, King's College Centre for Military Health Research, King's College. Professor Wessely is the UK's expert in dealing with mental health issues regarding UK serving personnel and veterans.

NHS TIL Veteran's Mental Health Services

In the UK the delegation spoke with representatives from the National Health Service (NHS) Veterans Mental Health Transition, Intervention and Liaison (TIL) unit for London and South East England. Dr Alyssa Joye, Clinical Psychologist and presentation by Cassandra McLaughlin, Clinical Nurse Specialist.

Unlike Australia, the UK has no dedicated government department for veteran's affairs to co-ordinate services. The NHS TIL unit provides free mental health services for armed forces personnel approaching discharge and veterans with mental health difficulties. Its services are:

- Transition: services for those leaving the armed forces
- Intervention: services for veterans with complex presentation
- Liaison: signposting and referral to appropriate NHS and 3rd sector health services

There are approximately 2.6 million veterans in the UK, with another estimated 6 million including, family and friends directly affected by the veteran's service. Of these, the delegation heard that:

- Approximately 200 military medical discharges per year are primarily for mental health
- 32 per cent of veterans report mental health problems
- Depression, anxiety, substance and alcohol abuse and PTSD are the most common afflictions
- 4-8 per cent (estimates vary) experience PTSD
- Prevalence of mental disorders is broadly similar to the general UK population
- They require similar interventions - but support offered to veterans is not always easily accessible
- Stigma deters many current and ex-service personnel from discussing mental health.

Ms McLaughlin explained that a 'typical' veteran reporting for help tends to present with many of the following characteristics, though this is by no means a full description:

- PTSD, anxiety, depression and alcohol misuse
- Socially isolated, vulnerable, long spells of homelessness and unemployment
- Family ultimatum – usually 2nd marriage
- Often lost touch with children
- Significant physical illness

- Childhood history of trauma and neglect
- Multiple traumatic exposure; service in many war theatres
- Northern Ireland service the most common

While PTSD is recognised as a serious problem for servicing personnel and veterans, it is by no means the most common mental health problem in service personnel. The delegation heard that in 2010, the UK Mental Health Foundation undertook a research project under its *Need2Know: The Mental Health of Veterans*, Executive Briefing which surveyed both serving personnel (regular and reserve). The survey found that most veterans developing mental health problems experience a common mental disorder such as depression or anxiety (27.2 per cent) with a smaller number diagnosed with PTSD (4.8 per cent). The most common and pervasive diagnoses was alcohol abuse (18 per cent) which can be linked to, and can exacerbate, mental health problems. Other neurotic disorders accounted for approximately 13.5 per cent, and reservists were at a greater risk of developing psychiatric problems than regular service personnel. Post-deployment reservists appear to be at a greater risk of developing psychiatric problems than regular service personnel, and younger men who have served for a relatively short period are at higher risk of suicide and are more likely to experience problems returning to civilian life.[33]

The challenges, TIL told the delegation, for dealing with veterans are being met through a variety of ways:

- Building directories of key NHS services (Crisis, Trauma, Community Mental Health Teams, and Improving Access to Psychological Therapies)
- Establishing network of Armed Forces champions in certain NHS services
- Identifying and creating links with major charities (Stoll offers housing and drop-in support[34], Poppy Factory for Employment, etc.)
- Recruiting suitable staff with good knowledge of other NHS services and local council practices[35]

Outcomes to date included:

- Rate of referrals to TLS continues to increase
- Referrals continue to come from a variety of sources
- Over 90% clients offered appointments within 14 days
- Increasing engagement with MOD/ military
- Outcomes measures of symptom management group show reductions in PTSD scores
- Clients are being provided housing and employment opportunities through TILS' links with effective charity/3rd sector services

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33 *Need 2 Know*: The Mental Health Of Veterans - Executive Briefing, https://www.mentalhealth.org.uk/publications/need-2-know-mental-health-veterans-executive-briefing

34 Stoll is the UK housing support for veterans, https://www.stoll.org.uk/housing/

35 Services for UK veterans, https://www.veteransservicelse.nhs.uk/veteran-specific/

- High success rate with discharges since TILS services began, not a single discharge has returned to service within 28 days
- 100% surveyed said that are 'likely' or 'extremely likely' to recommend the TILS to friends and family

Many of the findings mentioned by the NHS TILS matched with those of Professor Wessely, who also impressed on the delegation that the primary affliction among veterans was in fact alcohol abuse.

Delegation meeting with NHS TILS representatives

Big White Wall (BWW) digital space

The delegation heard about a couple of tools being used to assist people with mental illness in the UK. One is an online interactive site called Big White Wall (BWW)[36] which began in the UK in 2007 in response to the lack of safe spaces to talk about mental health online. The service is now commissioned by multiple NHS and private healthcare providers, local authorities, employers and universities in the UK, Canada and New Zealand. Members of the BWW are able to engage anonymously, one on one, in groups or with the wider online community, express themselves creatively, and gain knowledge and self-awareness through available information resources. There are also a range of evidence-based online courses, tips and clinical tests on topics including managing anxiety, positive thinking, smoking cessation and weight management. The service is available 24/7, 365 days a year, with counsellors online to moderate the service and provide further support.

36 Big White Wall digital space, https://www.bigwhitewall.com/v2/Home.aspx?ReturnUrl=%2f

King's Eating Disorders Research Group

While at King's, the delegation met with Professor Janet Treasure OBE, Co-Director, and her colleague Professor Ulrike Schmidt, Co-Director, Eating Disorders Research Group, King's College and its clinical arm, South London and Maudsley's (SLaM) Eating Disorders Service (EDS). Professor Treasure and Schmidt and their unit are internationally renowned for their research and are at the forefront of treatment development, having generated much of the evidence underpinning contemporary eating disorder treatments.

The delegation was informed that an eating disorder is a phrase that describes conditions in which individuals engage in disordered eating. It is recognised by most to be a mental health condition in which harmful eating habits can lead to a range of emotional issues. According to Professor Treasure, the three most common eating disorders are anorexia nervosa (anorexia), bulimia nervosa (bulimia), and binge eating disorder. Diabulimia is a condition which is now being recognised as an eating disorder and something that is now treated at the EDS.[37]

The delegation heard that people with eating disorders are preoccupied with food and/or their weight and body shape, and are usually highly dissatisfied with their body and appearance. The majority of eating disorders involve low self-esteem, shame and secrecy. Anorexia nervosa, bulimia nervosa, binge eating disorders are the major eating disorders. In addition, there are many people, who do not neatly fit into any of these groups and instead have a mixture of symptoms often presenting with comorbidity.

Professor Treasure told the delegation that disorders are complex illnesses with no single cause. Psychological, interpersonal, socio-cultural and biological factors all seem to play a role. A person is more likely to develop an eating disorder if they have low self-esteem, a tendency to be a perfectionist, or they are shy, anxious and over-controlled or rash and possibly impulsive in their nature. One area that Professor Treasure said they are conducting increasing research into is whether genetics could play a role in the affliction of anorexia. Increasingly the impact of social media is playing a large role, Professor Treasure spoke of the need to build greater resilience to live with life and the modern world.

An important part of the work involves family members and carers, helping them come to an understanding of eating disorders, their likely causes and their consequences. EDS also offer an extensive programme of training and consultancy for eating disorder professionals, voluntary workers and teams, run an outpatient service and day care unit at the Maudsley Hospital, and an inpatient unit and rehabilitation service based at Bethlem Royal Hospital.

REACH: Resilience, Ethnicity, and Adolescent Mental Health Study in schools

In the afternoon of 27 September 2017, the delegation met with Dr Gemma Knowles, Dr Stephanie Beards and Dr Charlotte Gayer-Anderson, three postdoctoral research students, from the Institute of Psychiatry, Psychology & Neuroscience, King's College involved in a mental health study of school students in South London. Dr Gemma Knowles told the delegation that they invite all young people in participating schools aged between 11 and 14 (Years 7 to 9) to take part in the programme. All those who take part will complete a short questionnaire about their mental health and positive and negative life experiences. Dr Knowles explained that some young people, chosen at random, will also be invited to complete a further questionnaire and some reasoning tasks. This will help REACH better

37 South London and the Maudsley, Health Information, Eating Disorders, http://www.slam.nhs.uk/patients-and-carers/health-information/eating-disorders

understand why, despite similar life experiences and backgrounds, some young people experience mental health problems and others don't.

The delegation heard that REACH intends expanding their programme over the coming year to other parts of London.

Netherlands

Thursday 28 September

The delegation travelled to the Netherlands on Thursday 28 September from the UK where it met with a number of research institutions and organisations before travelling on to Sweden.

Netherlands health system

The Dutch health system is supported by statutory health insurance model. The system is tiered in terms of responsibility with the national federal government responsible for setting health care priorities, introducing legislation or legislative changes, monitoring access, quality and costs, and supporting evidence-based research. The federal government also partly finances the social health insurance for what's referred to as the 'basic benefit package' (through subsidies from general taxation and reallocation of payroll levies among insurers via a risk adjustment system), and the compulsory social health insurance system for long-term care. There are 12 provinces and 393 municipalities and 24 water boards. The municipalities and health insurers are responsible for most outpatient long-term services and all youth care under a provision-based approach (with a high level of freedom at the local level).

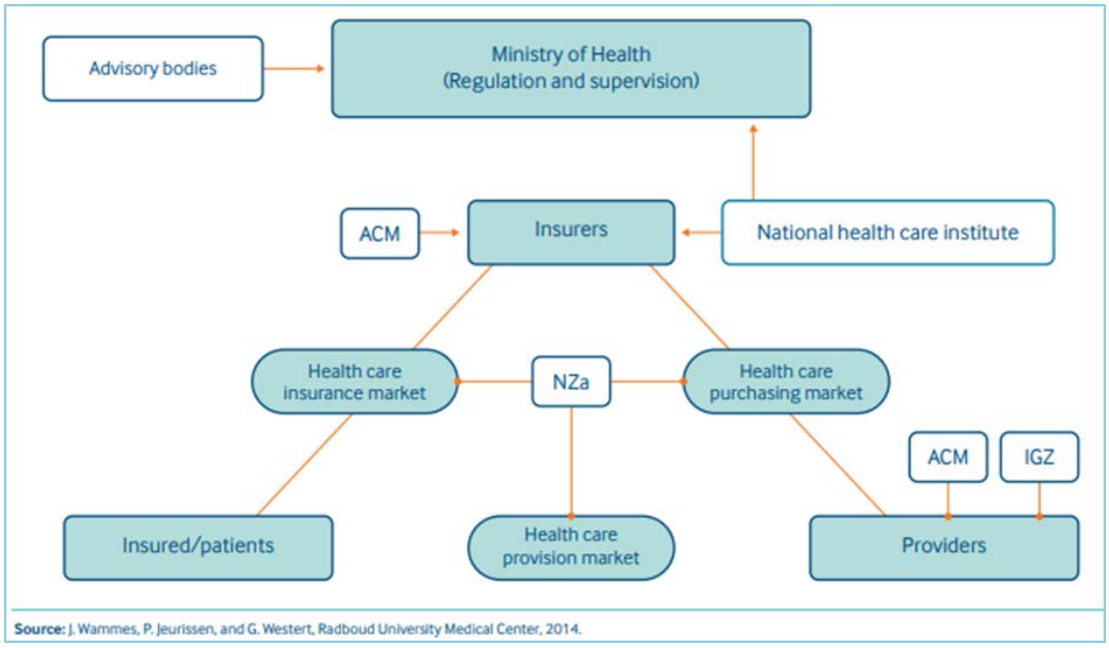

Diagram 2 Structure of the Netherlands health system

(NZa) Is the Dutch Healthcare Authority, an independent administrative body that supervises the healthcare market in the Netherlands, both on healthcare providers and insurers.
(ACM) Netherlands Authority for Consumers and Markets, is an independent regulator that looks after the rights of consumers and businesses.
(IGZ) Inspectie voor de Gezondheidszorg is the Dutch Health Care Inspectorate which is a governmental institution that supervises public health in the Netherlands.

According to the Dutch Ministry for Health, in 2015, the Netherlands spent approximately 11.8 per cent of its GDP on health care (approximately €71.3 billion). In terms of the Dutch healthcare workforce, there are approximately 1.1 million healthcare workers (excluding volunteers) and over 8879 GPs with around 14,000 medical specialists.

Approximately 77 percent (2014 estimate) of curative health care services were publicly financed. All residents (and non-residents who pay Dutch income tax) are mandated to purchase statutory health insurance from private insurers. At the end of 2014, 30,000 people (less than 0.2% of the population) were uninsured.[38]

Ministry of Health, Welfare and Sport

The delegation met with Ms Daphne Dernison, Senior Adviser, Ministry of Health, Welfare and Sport. Ms Dernison provided the delegation with an overview of the present Dutch health and mental health system and some the reforms underway.

The general principles for the Dutch healthcare system as outlined by representatives of the Ministry of Health, Welfare and Sport are:

- access to healthcare for all
- solidarity through medical insurance
- high quality healthcare services

Dutch primary care

Primary care is largely dealt with by the GPs and any need for hospitalisation or specialist care is only at the referral of a GP—94 per cent of all medical complaints are dealt with by GPs. GP registration is not formally required of individuals, though most people are registered with one they have chosen, and they can switch GPs without any restriction. All out-patient specialist care is generally undertaken in a hospital environment as most specialists are based in hospitals in the Netherlands.

The delegation heard that there are some multidisciplinary/ambulatory centres being established, but this is still marginal. As outlined, the health system is a national insurance model with managed competition as there is a mix of market incentives/private ownership and government regulation including safeguards. All general and specialised hospitals are private but non-profit.

The basic premise is that all insured individuals have a choice of insurer (can change your insurer every year). As of 2016, every insured person over age 18 must pay an annual deductible of €385 for health care costs, including costs of hospital admission and prescription drugs but excluding some services, such as GP visits.

Key Dutch initiatives and reforms

Early reforms (2006) sought to manage effective competition in the market, which included ensuring individuals choice of insurer, allowing health providers to compete for contracts with national insurers, and for insurers to compete for the insured population based on premium, quality and service level. Later reforms have seen an agenda to limit financial growth in the sector to around one per cent growth. The Ministry note that this has largely been maintained since 2013. Ideally the aim of the reforms, as Ms Dernison noted, is to ultimately spend in 2017 the same amount on care and social support as was spent in 2012.

The largest tranche of reforms commencing in 2015, have looked to undertake decentralisation of long-term care for physically and mentally disabled to the municipalities; a reduction in residential care (deinstitutionalisation), recognising that people live longer in their own home when supported by wrap around care networks; and the re-introduction of the

38 2017 International Profiles of Health Care Systems, The Commonwealth Fund, p.113.

community nurses. This aspect has seen a substitution shift of care towards GPs (primary care) and community care. As part of the reforms, there has been further decentralisation to the municipalities, along with a more tailored support encompassing a move to reform the 'standard entitlement' to a needs-based support which is a rationalisation of care services particularly for home care. Also included, in this raft of reforms was the introduction of larger financial contributions [co-payments] from patients outside of the insurance model.[39]

Innovations and e-Health

Ms Dernison told the delegation that innovation is also an area that requires extra support according to:

- a lot of new technology supporting healthcare is under-used;
- there is a lot of potential for self-care and self-management in healthcare;
- better healthcare outcomes, more in accordance with patient needs could be reached (reducing mis-use);
- using e-Health is an instrument in reducing the cost of healthcare.

Ms Dernison said there are three major e-Health goals:

- within 5 years 80 per cent of the chronic ill patients access to their own medical data;
- within 5 years 75 per cent of the chronic patients and fragile elderly (who wants to do so) are able to measure and monitor their own health at home and communicate those data with their healthcare providers; and
- within 5 years everybody who needs healthcare is able to communicate via iPad or screen with their healthcare providers.

Novarum

The first meeting the delegation attended in the Netherlands was with the Managing Director, Ms Elske van den Berg, Daniela Schlochtermeier, Psychologist at the research and treatment organisation Novarum, which is one of the largest facilities in the Netherlands for treating eating disorders. Ms van den Berg stated that Novarum was the first eating disorder treatment centre in the Netherlands to use Cognitive Behavior Therapy Enhanced (CBT-E) methodology as a treatment option.

The delegation was informed that the effectiveness of the CBT-E methodology is higher than conventional therapies, and the average time for treatment as an in-patient is therefore shorter. Novarum has also gained experience with treating patients with comorbidity—multiple problems, (e.g. obesity and depression). Besides offering treatment, Novarum provides education services to practitioners and research activities focusing on abnormal eating patterns and limited self-control.

Presently Novarum provides services to 900 patients per year (over 18 years) with most services for out-patients, though it states that they intend to decrease out-patient services in preference for in-patients. Novarum claimed that they achieve a 61 per cent success rate and would like to increase that rate to 70 per cent in the near future. They note that 40 per cent of all clients have had prior treatment before they arrive at Novarum, with 60 per cent presenting with comorbidity issues such as, anxiety, depression or personality disorders.

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39 Ministry of Health, Welfare and Sport, Healthcare in the Netherlands Power point briefing, 2017.

The average cost of treatment is approximately €5800 though this can range up to €25,000. The delegation heard that while treatment time is fixed (and must be delivered at Novarum with no breaks), the successful implementation of CBT-E treatment has reduced treatment time down from nine months to eight weeks reducing costs significantly. The treatment is personalised and varies according to individual circumstances, working in a collaborative approach between the individual and therapist. Ms van den Berg stated that Novarum intends moving away from group therapy as it finds that individuals can easily disappear into 'the group environment' and avoid addressing their own particular issues. The delegation also heard that the basic premise of Novarum is the principle of parsimony; that things are usually connected or behave in the simplest or most economical way; as such, Novarum's adage was 'better to do a few things right than many things bad'.

MEE Zuid-Holland Noord

In the afternoon, the delegation met with staff from MEE Zuid-Holland Noord (MEE), a social welfare organisation that offers information, advice and support to the mentally or physically impaired. MEE supports people with disabilities so that they can participate in society. MEE specialises in assisting people with mental or physical disabilities, chronic disease, autism and non-congenital brain injury. They provide case management or job placement and assistance services. A unique training discussed with the delegation was MEE's 'baby awareness' training, designed to help people with mental or physical disabilities cope with child rearing.

The MEE service is a local community-based service. Individuals are referral by a local GP with the aim to assist people socially as opposed to GP's clinical/medical services. One aspect of this service is the focus on trying to find help in the community before accessing any social security, which includes trying to develop networks among—family, friends, acquaintances, neighbours of the client. Intervention is always seen as a last resort.

The visit included a tour of Parkoers, a local small-scale meeting and conference centre and café staffed by people with a mental or physical impairment. The café provides the opportunity to train people (with some accreditation), helping them learn a skill while also learning to regulate their emotions in work environments. The café also trains employers in how to deal with people with intellectual disabilities.

Members of the delegation with representatives from MEE Zuid-Holland Noord and view of their café (left).

Dr Rene Keet, Medical Director, GGZ-Noord-Holland-Noord

On the morning of Friday 29 September, the delegation had a breakfast meeting with Dr René Keet, a psychiatrist and medical director of the community mental health service GGZ-Noord-Holland-Noord. Dr Keet provided the delegation with an insight to the current thinking on mental health in both the Netherlands and the EU generally. Dr Keet specialises in integrated recovery oriented treatment of people with severe mental illness. He is also Chair of the European Community Mental Health Services network (EuCoMS), a network of services in 16 European countries. His research experience is in the European First Episode Schizophrenia Trial (EUFEST), Family Motivational Intervention (FMI) and evaluation of the introduction of Flexible Assertive Community Treatment (FACT).

Dr Keet stated that assertive community treatment has been established as an effective treatment model for patients with severe mental illness (SMI). The essential ingredients of the FACT model are: a multidisciplinary team with small, shared caseloads, home based treatment and out-of-hours availability. In addition, FACT provides integrated dual diagnosis treatment, supports paid employment and includes peer support often in a community setting.

Dr Keet told the delegation that the main operation of mental health services are still focussed in Dutch hospitals, with FACT services being used in outreach services. There needs to be an increased awareness that there should be far greater integration with other services, much like models in the US. With the federal government reforms and closing of large institutions there have been both good and bad outcomes for the individual' particularly when dealing with episodic care for patients experiencing a psychiatric crisis. Dr Keet told the delegation that there needs to be greater flexibility in the system to be able to scale services up and down as these episodes require.

Dr Keet explained a method of short-term, specialised out-patient crisis intervention by a Crisis Resolution Team (CRT), called Intensive Home Treatment (IHT), which is an alternative to hospitalisation for such acute events. However, access to IHT is dependent on the availability and training of a suitable workforce because of the required Individual Patient Support (IPS).

Technology is also enabling better and quicker services and diagnostics. Dr Keet spoke of the 'Digital Ward', where daily updates and assessments can be undertaken with patients who are still in the community and digital assessments can be done in the field, particularly in the case of emergencies like IHT situations.

Trimbos Institute at Residence

In the afternoon the delegation met with members from the Trimbos Institute, Mr Rutger Engels, Ms Ionela Petrea and Ms Laura Shiels. The Institute conducts research on mental health, mental resilience, addictions, and healthcare systems. This research has been used to improve healthcare delivery, policies regarding mental health and addictions, and health education for clinicians and the general public.

Mr Engels discussed the Dutch health and mental health system, noting that it presently leads the European Health Consumer index as a probable result of the government contributing 9.6 per cent of the health budget toward mental health spending. However, Mr Engels also noted that even though the Netherlands has some of the highest employment figures for mental health care professional staff, funding of mental health services is still very fragmented, and the number of available psychiatric beds has reduced over time due to the reforms. However the corollary to this, Mr Engels noted, was "if you have a bed, you will fill it".

Despite the high number of places in in-patient settings, Mr Engels noted that data on the utilisation of mental health specialist services show that 92 per cent of people in contact with specialist services in 2010 received care in out-patient settings. Against this backdrop Mr Engels stated that over the last eight years the Dutch mental health system has been subject to numerous policy changes. Significantly, the decentralisation policies have seen a large shift from clinical settings to outpatient and from specialist to primary care. With deinstitutionalisation there has been 30 per cent reduction of clinical beds and a shift of 20 per cent of clients from specialists to GP's and nurses. This has obviously led to a slow decrease of clinical capacity and a sharp increase of community mental health teams. As such, 31 trust organisations provide 81 per cent of mental health care and more than 80 per cent of GP clinics have a resident mental health nurse in the clinic.

Association of Dutch Municipalities

Mr Ico Kloppenburg, from the Association of Dutch Municipalities (Vereniging van Nederlandse Gemeenten or VNG), and staff spoke briefly with the delegation about the role of local authorities in the social support system. The VNG was established in 1912 to represent all municipalities—off which there are 393. The VNG facilitates municipalities with the exchange of knowledge and experience regarding the implementation of national and local policies, laws and regulations. It also lobbies on behalf of the municipalities in numerous platforms. Mr Kloppenburg stated that its core tasks are:

- advocacy
- services
- platform for municipalities
- development of products and services

Mr Kloppenburg noted with the 2015 reforms to the Social Security Act, Health Insurance Act and the Long term Care Act, many responsibilities have been transferred along with funding to the municipalities including: youth care, assisted living, and housing etc. He also noted that VNG assists in its advocacy role within local and federal government and helps the municipalities with exchange of information and best practices provision.

Sweden:

On 2 October 2017, the delegation arrived in Sweden and undertook a number of meetings with researchers and practitioners around Stockholm.

Swedish health system

The Swedish health system is a publically funded model with automatic universal coverage. The health system is devolved among three levels of government. At the national federal level is the Ministry of Health and Social Affairs, responsible for overall health and health care policy, which works with eight national government agencies. It is not a direct provider of any healthcare services. At the regional level, there are 21 county councils and nine regional bodies which are responsible for financing and the delivery of health services to citizens.

At the local level there are 290 municipalities (municipal councils), who are the main decision making bodies in the country responsible for running preschools, schools, aged and disability care, individual and family services, roads, water etc. care of the elderly and the disabled.

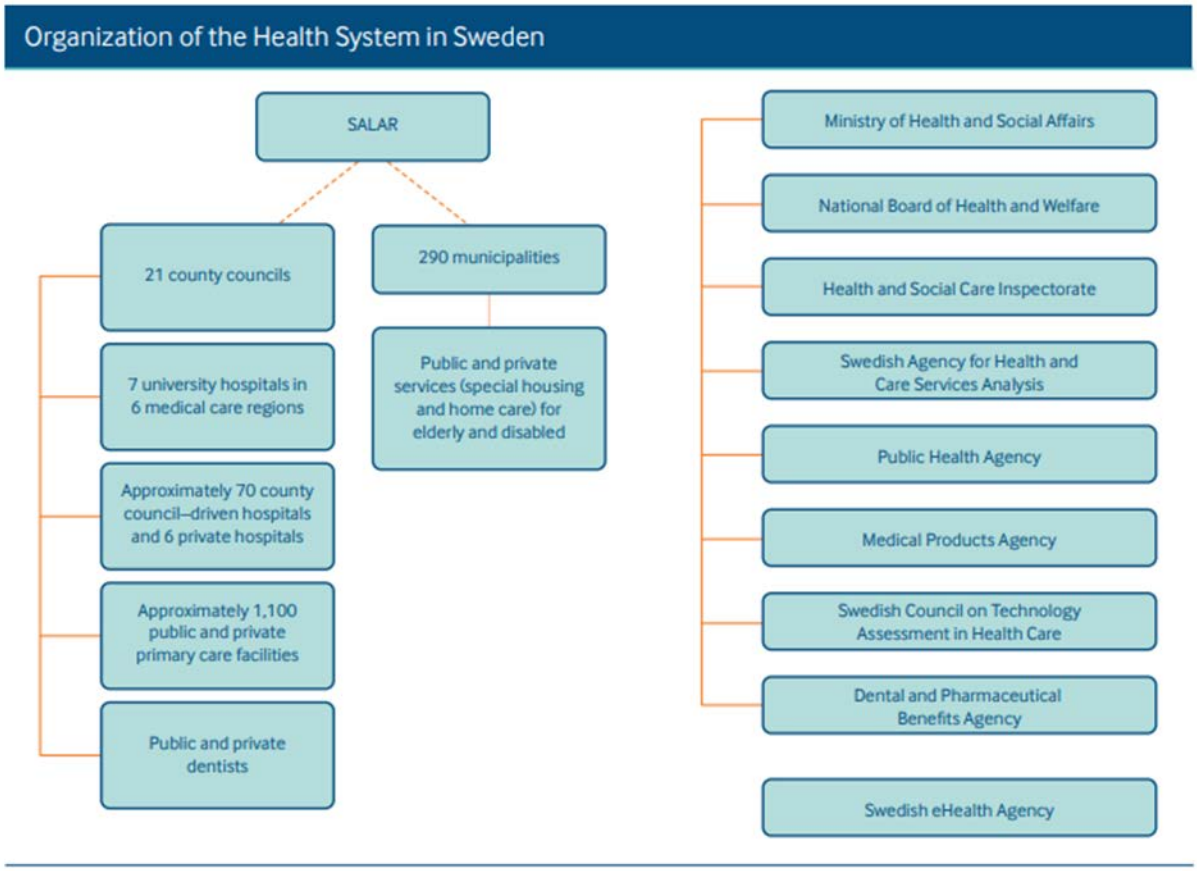

Diagram 3. Structure of the Swedish health system

The local and regional authorities are represented by the Swedish Association of Local Authorities and Regions (SALAR). Services are funded through municipal taxes and grants and fees from the Federal Government. Other interesting facts about Sweden include its:

- very low level of hospital beds with an average length of stay at 5.9 days.
- higher than the EU average numbers of doctors and nurses per head of population.
- high use of electronic patient records and e-Prescriptions.
- maximum waiting times for a range of services is set by the Health Care Guarantee Act. Though compliance with this guarantee varies largely across the country and no region has fully been able to meet the rules.

At 11 per cent, Sweden has the third highest healthcare spending as a proportion of GDP in the EU[40] and the highest of all countries visited by the delegation.

The delegation heard that the Swedish Government undertook a mental health review to examine how the country was addressing mental health and mental illness, noting how interrelated the two are and to reach a point where mental health becomes equally as important as mental illness. As a result of this review, the government decided to strengthen preventive and promotional efforts and provide early and effective interventions for those affected with mental health and attempt to better utilise specialised health care resources.

40 EU 2015 average was 9.9 per cent.

National Strategy Mental health 2016-2020–Five focus area for the next five years

In 2016, the Swedish Government adopted a national strategy for mental health for the period 2016-2020. The strategy is based on five focus areas that have been identified as the main challenges when it comes to strengthening mental health, wellbeing and combating mental ill health. The strategy notes that "It is important to bear in mind that each focus area covers people of all ages—children, young people, adults and the elderly—as well as girls and boys, men and women."[41]

The five focus areas identified as the main challenges in combating mental ill health are:

1. Preventive and promotional efforts—preventive and promotional efforts regarding mental health are required simultaneously in many different contexts and settings, and need to be well coordinated.
2. Accessible services early—people suffering from mental health problems—regardless of age, gender and the nature and severity of illness—must be able to access the right health-care and social services at the right time.
3. Vulnerable groups—anyone suffering from mental health problems should have equal access to good and safe health care and social care in accordance with the best knowledge available.
4. Participation and rights—people who live their whole life with mental illness still encounter shortcomings in the health care system.
5. Organization and leadership—design of services to prevent ill health.

Apart from the main focus areas, the strategy's rationale sets out the requirements for change. These include:

- a recognition that the strategy needs to be owned by all involved
- it needs to have a person-centred approach
- it needs to ensure it collects and is able to access the right data at the right time
- the authorities responsible for knowledge support must be responsive to the service providers in their efforts to meet the needs of service users and families
- it must being cost effective—prevention and early intervention need to be a high priority to reduce more expensive specialist interventions later
- it needs collaboration at all levels to bring about change.
- And ultimately, the experiences of patients, users and relatives are of the greatest importance.

Delegation Meetings

The delegation visited a number of research groups at the Karolinska Institutet located at the KI Science Park outside of Stockholm.

Monday 2 October

41 The Government Strategy in the area of mental health 2016-2020, Five focus areas for the next five years. 2016, http://samordnarepsykiskhalsa.se/

Mandometer Clinic, KI Science Park

The delegation began its visit to Sweden by meeting with Dr Cecilia Bergh, CEO, and Professor Per Sodersten of the Mandometer Clinic, KI Science Park Karolinska, University Hospital. The Mandometer Clinic is part of the privately owned healthcare company Mando Group AB operating in three countries, including in Melbourne, Australia. The Mando Clinic treats anorexia nervosa and bulimia nervosa, along with all other eating disorders using the Mandometer method.

The primary focus of the clinic has been on treating eating disorders and to normalise eating behaviour. In addition to providing specialist care for eating disorders, the Mando Clinic also provides education, conducts research, and undertakes continual technological development with the aim of improving care for patients with eating disorders and obesity.

Dr Bergh discussed the difference in the use of medications, primarily SSRI anti-depressants for treating eating disorders noting that from their studies they have found that SSRI's have no effect on the psychopathology of anorexia and have been over prescribed. [42]

Dr Bergh discussed the patient treatment that Mando Clinic provides; the results of the treatment and the prevention of eating disorders and obesity. Reference was made to the fact that such disorders are often treated as mental health problems in many other countries. The important aspect of dealing with eating disorders, Dr Bergh said, is to instil a behavioural change to normalise food intake, eating behaviours and activity levels of normal living. It is through restoration of these behaviours that people with disorders are able to return to normal life. Dr Sodersten also referenced peer reviewed published research work that supported the Mando Clinic's approach of normalising eating behaviour as more beneficial than cognitive behaviour therapy (CBT) for the treatment of bulimia nervosa and other eating disorders. He informed the delegation that:

> …recent trials focusing on the abnormal cognitive and emotional aspects of bulimia have reported a remission rate of about 45 per cent, and a relapse rate of about 30 per cent within one year. Whereas an early CBT trial that emphasised the normalisation of eating behaviour had a better outcome than treatment that focused on cognitive intervention.
>
> In support of this finding, another treatment, that restores a normal eating behaviour using mealtime feedback, [Like the Mandometer] has an estimated remission rate of about 75 per cent and a relapse rate of about 10 per cent over five years. Moreover, when eating behaviour was normalised, cognitive and emotional abnormalities were resolved at remission without cognitive therapy. The critical aspect of the CBT treatment of bulimia nervosa therefore may actually have been the normalization of eating behaviour.[43]

Mando Clinic's treatment has a four corner stone approach to: normalise eating behaviour, decrease physical activity, heat and rest (to reduce the need to compensate for eating with

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42 Selective serotonin reuptake inhibitors (SSRIs) are a class of drugs that are typically used as antidepressants in the treatment of major depressive disorder and anxiety disorders.

43 P. Södersten, C. Bergh, M. Leon, U. Brodin, M. Zandian, Cognitive behavior therapy for eating disorders versus normalization of eating behaviour, Elsevier, Physiology & Behavior, 2017, pp.174 178–190.

physical activity) and social reconstruction (personal case managers assist in rebuilding confidence and motivate towards recovery).

During the visit to the Clinic, the delegation also met with two Australian female patients, who had successfully completed the program in Sweden. Dr Sodersten said the program's results show a 75 per cent remission rate in patients at the clinic and they are symptom free at the end of the treatment. Also, 90 per cent of those who achieve remission are still healthy five years after treatment. The general treatment takes on average 12 months. In terms of obesity, Dr Bergh said that people have evolved to adapt to starvation, meaning we now lack the capacity to resist today's easy access to food. As such, today's issue with being overweight is not a character/mental problem rather it is behavioural and we need to teach people how to eat normally.

Delegation meeting with Mando Clinic representatives

Like eating disorders, the Clinic has a four cornerstone approach for obesity: learning to eat normally with Mandometer; training with their SatietyMeter software to stop snacking, develop an individual treatment plan with a therapist, and follow-up assessment for five years. The critical thing is, it's not calorie counting, its eating appropriately Dr Bergh told the delegation. Dr Bergh stated that the process requires the individual placing a plate of food on the Mandometer, a small device that weighs the food. This device links to a phone app (SatietyMeter) that registers decreases in weight as you take food from your plate, and generates a graphical representation of your eating speed that is matched against a reference curve for normal eating speed on the app. Periodically, you are asked to rate how full you feel. With the help of a second reference curve that appears on the screen, you learn to know how full you should be feeling over the course of a meal. The Mandometer is used every day for all main meals until eating behaviour is normalised. It usually takes 3-4 months to get accustomed to eating with the device. The clinic does receive funding from the Stockholm council and is looking to expand further internationally.

Dr Bergh and Dr Sodersten provided further information about the economics of the eating disorders and the benefits of the device.

Swedish Parliamentary Committee on Health and Welfare

The delegation was invited as guests of the Chair, Ms Emma Henricksson, and the Deputy Chair, Ms Sultan Kayhan of the Swedish Parliamentary Committee on Health and Welfare in the Riksdag [Parliament House]. The Chair and Deputy Chair provided the delegation with and overview of the work they do on the committee and some of the issues facing Sweden. The Chair told the delegation that the committee is responsible for examining matters concerning care and welfare services. Specifically, this covers health and medical care services for:

- children and young people (except for pre-school activities);
- for schoolchildren;
- elderly and the disabled and their welfare; and
- measures to combat drug and alcohol abuse and other social service questions.

It also includes preparing matters concerning alcohol policy measures, care and social welfare questions in general.

Ms Henricksson and Ms Kayhan discussed some of the main issues facing young people in Sweden; they noted that gaming is very popular and alongside of this, there has been an increase in anxiety and depression reported in young people. They told the delegation that the alcohol use has declined, though were unsure about the prevalence of other drug use. Of particular concern is an increase in youth suicide, which is currently the second highest cause of youth deaths. They spoke about the issue of social media and how its effect on young people is of a concern, especially in regard to the youth suicide rates.

Delegation meeting with the Chair, Ms Emma Henricksson, (second left) and the Deputy Chair, Ms Sultan Kayhan (second right) of the Swedish Parliamentary Committee on Health and Welfare

Ms Kayhan told the delegation that schools do undertake mental health work. Some schools have mental health nurses based in them, though there are not enough schools employing these nurses. Psychologists and GPs are also available in some schools though there is a long waiting period to see a professional.

Ms Henricksson and Ms Kayhan said that Sweden does not disaggregated mental health identity data by ethnicity as this is perceived as being possibly discriminatory. Subsequently, no data is available on the Indigenous Sami population in the north of the country.

The delegation heard that educational outcomes are good to fair among Sweden's young people, though PISA[44] rates are not doing so well, especially when compared to Finland. Those who come from low-socio economic backgrounds and state care children do poorly in their educational outcomes. Sweden continues to monitor their performance through their schooling years up until the age of 18 years.

National Board of Health and Welfare

The delegation met with Ms Birgitta Lindelius, Head of Unit Socialstyrelsen from the National Board of Health and Welfare (The Board). The delegation heard that the Board has a statutory obligation to collect data (incl individual patient data). It also maintains registers, from which it produces statistics, provides advice and disseminates information related to social/health care across Sweden in order improve healthcare outcomes. It also publishes summary reports on the latest evidence-based health and care research. Additionally, the Board is responsible for a wide range of other activities, for example:

- developing standards based on legislation, producing regulations and general advice on how to comply with both the legislation and the regulations. This includes evaluating how legislation is applied as well as the impacts of reforms and policy decisions;
- issuing professional licenses across 21 professions and overseeing a Medical Responsibility Board to examine issues and non-compliance;
- developing knowledge-based guidance, (information collated from eight health research and regulatory authorities) to inform better delivery of services and policy/legislation development; and
- co-ordinating health and medical care operations in the event of a serious crisis.

A key register that the Board maintains is the National Patient Register, which houses data on both psychiatric and somatic care, in-patient and out-patient visits to hospitals and other specialised care facilities. Statistics Sweden and the Board also collects other data at the individual level for all Swedish residents, which ranges from medical diagnoses to socio-economic information. In addition to the information collected by governmental agencies the medical profession has initiated nationwide Quality Registers (approximately100 nationally funded registers) that collect data on specific diagnoses and interventions such as eating disorders, mental health or oncology.

The delegation heard that data collection is mandated by law and patients cannot opt out, there is a lot of data-sharing between different government agencies. A ten-digit-PIN is maintained by the Swedish National Tax Board for all individuals that have resided in Sweden since 1947. Every individual that has resided in Sweden on a permanent basis since 1947 (and been recorded in the Total population register, TPR) has been assigned a PIN.[45]

Because the PIN has only three parts—date of birth, a three-digit birth number, and a check digit, it is de-identified and lacks information on specific demographics so the Board is unable to identify for specific ethnic groups like the indigenous Sami and CALM communities.

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44 The Programme for International Student Assessment (PISA) is an international assessment measuring student performance in reading, mathematical and scientific literacy.

45 Jonas F. Ludvigsson, Petra Otterblad-Olausson, Birgitta U. Pettersson, and Anders Ekbom, The Swedish personal identity number: possibilities and pitfalls in healthcare and medical research, 2009, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2773709/

Outside health care, the PIN is used for population statistics, migration, taxation, education, passports, income, and social security etc. It is also used for conscription purposes and by insurance companies.[46]

Since 2006, the Board has published annual regional comparisons on different subjects. The purpose of these reports is to provide an overview of how different subject areas are performing to assist decision/policy-makers at national, regional, and the local level to ensure efficiency and quality in Sweden's healthcare system.

Veteran Centre, Swedish Armed Forces

The delegation met with Sergeant Major Daniel Nybling, Swedish Department of Veterans Affairs Forsvarsmakten. Sergeant Nybling provided the delegation with an overview of the Swedish Armed Forces and some of the issues with supporting Swedish veterans.

The delegation heard that the Swedish forces have not had a combat role in over 200 years; as such, there are no combat veterans. Foreign deployment is strictly for peace support operations led by the international community in form of the United Nations, the European Union or NATO. The Balkans conflict was the first time Sweden decided to implement a 'homecoming' support system for returning veterans. Following deployment to Afghanistan and parliamentary inquiry, a strategy was developed to better support returned veterans and their families. The long-term goal is to construct a Veteran's Policy that covers the whole spectra of issues connected to International Operations and that involve more departments in addition to the Department of Defence. The delegation was told that the rationale for developing this policy is to support Sweden's participation in international peacekeeping operations as it is deemed as a responsibility for the Swedish society as a whole, and not just the Swedish Armed Forces.

Swedish welfare system

Swedish welfare is constructed in such a way that any need for professional medical support to the veteran or their family, both physical and mental, is handled by the same system that cares for the rest of the Swedish population—there is no separate medical facilities to care for veterans. Social rehabilitation and counselling is available in each municipality and the Swedish church also provides family counselling.

Profile of Veterans

The delegation was told on the basis of a large national study, that the vast majority of Swedish veterans are positive, healthy and well. The study compared veterans with a matched control group rather than with the average Swede. This was done by matching the physical and mental test results from when the Swedish Defence Forces tested all potential conscripts and comparing veterans with equally tested non-veterans. The veterans showed lower suicide and mortality rate, less use of anti-depressants and fewer convictions for violent crimes. However, one factor that did stand out was a higher incidence of divorce. This result has prompted development of greater family support for soldiers and veterans.

Pre-deployment system-enhancing mental resilience

Sweden has implemented a range of pre-deployment activities to enhance mental health and post-deployment support is also available. During pre-deployment soldiers are given training

46 Jonas F. Ludvigsson, Petra Otterblad-Olausson, Birgitta U. Pettersson, and Anders Ekbom, The Swedish personal identity number: possibilities and pitfalls in healthcare and medical research, 2009, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2773709/

and information regarding mental health and the expected strain that international service will place on them. Part of this involves understanding how to normalise common reactions, and providing tools to help identify possible symptoms before they become acute. Sweden has also adopted the US Marine Corps “Combat Operational Stress Control” (COSC) program to assist in this as well.

Family gatherings have been implemented as part of pre-deployment briefings to share information and provide a network for veterans and families.

During deployment

During deployment the delegation heard that the army is using a new mental health tool for continuous monitoring of mental health and performance. This includes weekly evaluations of stress and anxiety and seeks to implement mitigation strategies to assist troops where needed.

Post-Deployment and follow-up

Sweden has a program of 5 year active post-deployment assessment. This starts with home-coming activities which include individual screening, squad/group conversations to reflect on the individual medical, mental and physical effects the deployment. A key element here is to establish normalised reactions, thoughts and challenges concerning the transition from "battle mind' to "home mind", and promote self-awareness using COSC methods. After six months there is a re-union, again with squad/group conversations, and re-cap on mental and physical health issues. This is then reduced to annual follow-up activities.

Life-long support

If a veteran experiences difficulties after five years, they might still be entitled to further support. There are also individual assistance measures for wounded veterans. It is still the general Swedish health care system which looks after the veteran. However, in some cases, the Defence forces might take out additional supportive measures to aid wounded veterans.

Financial support

Swedish veterans can apply for Veteran Card (Veterankort.se) which gives the bearer benefits and rewards from different businesses and organisations. The Swedish Government provides grants to non-profit organizations that support veterans.

KI Centre for Psychiatry Research Unit

In the morning on Tuesday 3 October, the delegation met with Ms Clara Hellner Gumpert, Head of Operations, CPF KI Centre for Psychiatry Research Unit and then with Ms Yvonne von Hausswoolf-Juhlin, Medical Director, Associate Professor Stockholm Center for Eating Disorders.

Karolinska Institutet Centre for Psychiatry Research

Ms Clara Hellner told the delegation that the Karolinska Institutet Centre for Psychiatry Research and the Stockholm Country Council is responsible for 40 per cent of the Sweden's research output and presently has some 6000 medical students and more than 2000 PhD students.

The Institute receives five year core funding agreements federally as well as commissions from the Stockholm Country Council which cover all of its costs, including administrative cost. The arrangement with the Stockholm Council is a collaborative research/clinical arrangement between the council and the institute in which the Institute provides:

- clinical psychiatry care including clinical development work;

- education including continuous professional education for clinical staff;
- internationally competitive research opportunities;
- undergraduate and postgraduate education; and
- Academic Health Care Centre

Stockholm Center for Eating Disorders

Associate Professor Hausswoolf-Juhlin outlineded the work the Stockholm Center for Eating Disorders undertakes and the current treatments for people with eating disorders in Sweden.

Associate Professor Hausswoolf-Juhlin explained that Stockholm has three clinics offering services for eating disorders (ED), Mandometer Clinic, Capio Eating disorder Clinic (both are private) and the Stockholm Center for Eating Disorders [Ätstörningar] (STA). The delegation heard that government funding is allocated to a provider by Swedish Commissioner of Mental Health following a needs-based assessment.

The delegation heard that there are 1700 ongoing patients receiving treatment in the Center with a further 900 new patients each year being admitted. While treatment is varied between out-patients, day treatment and in-patients at the Center, many of the 1700 are long term patients who are treated as out-patients. The majority of the patients are female aged 14-16 years old. The delegation was told that with the closure of large institutions in 1995, there has been a scarcity of in-patient beds and that the transition from those large institutions was too quick as the appropriate community-based support had not been developed sufficiently to cope with the changes, resulting is ongoing homelessness for some patients.

Associate Professor Hausswoolf-Juhlin outlined STA's treatment methods, which include:

- Family Based Treatment (FBT) for children and adolescents.
- Enhanced Cognitive Behavior Therapy (CBT-E) for adults.

In contrast to the Mando Clinic's approach and Mando's research findings regarding (CBT-E), Associate Professor Hausswoolf-Juhlin explained that 50 per cent of those who received CBT-E or FBT in STA no longer have an ED diagnosis after treatment and 70 per cent have no ED diagnosis after one year of follow-up in Riksät (National Quality Register for Eating Disorder).

KI National Centre for Suicide Research and Prevention of Mental lll-Health

Also at KI Science Park, the delegation met with Professor Danuta Wassman, Head and Founder of National Centre for Suicide Research and Prevention (NASP) of Mental ill-Health and Dr Vladimir Carli Senior Lecturer, KI NASP.

Professor Wassman, a leading expert in youth suicide and mental illness, explained that worldwide, suicidal behaviours in adolescents are a major public health problem and evidence-based prevention programmes are greatly needed. NASP has undertaken to investigate and develop the efficacy of school-based preventive interventions to minimise suicidal behaviours.

Professor Wassman recounted that, globally, suicide is the second major cause of death in the 15–19 year age group, the first being road traffic accidents. While the long-term global average of teenage suicides rates have declined over the past two decades, from the 1990 high of 8.5 suicides per 100,000 teenagers to 7.4 in 2015, persistence in the numbers remains a concern. Some countries in recent years have seen large changes in teenage suicide rates since the early 1990s. For example, Japan, Mexico, Lithuania and New Zealand have all seen particularly large increases in suicide rates since 1990s, while Finland, Norway and Iceland

all saw suicide rates fall over this period.[47] Currently, WHO's Suicide Mortality rate reporting shows Sweden has a rate of 14.4 (2016) against a regional average of 15.4 for most European countries. In the Western Pacific cohort, Australia, against a regional average of 10.2, sits above the average at 13.2 deaths per 100,000.[48]

Professor Wassman told the delegation that attempts at suicide together with suicidal ideation have serious consequences, including substantial psychological effects, increased risk of subsequent suicide attempt, and death. Furthermore, suicidal behaviour has profound negative effects on the individual and the family broadly. Such behaviours are a major public health problem, not to mention the impact on medical, financial, and emotional costs to those communities affected.

Professor Wassman informed the delegation that all of NASP's patients are children/teenagers generally in the teenage age cohort. She outlined of some of the mental health issues that present to her such as, Obsessive Compulsive Disorder (OCD), SSRIs,[49] Body Dismorphic Disorder (BDD), and Tourette syndrome. Professor Wassman said that it was important in many instances to get early intervention regarding these disorders.

NASP, in collaboration with a number of other research organisations, have developed a program called Youth Aware of Mental Health, (YAM). This is an evidence-based mental health promotion and suicide prevention programme developed for youth through collaboration between researchers at the Karolinska Institute and Columbia University (USA) which has been implemented in a number of countries, including Australia (NSW Government and Black Dog ltd pty). YAM is an interactive programme for adolescents designed to promote discussion and awareness and knowledge about mental health and to develop problem solving skills and emotional intelligence. The course involves interactive role plays session framed around three main themes: everyday choices and the outcomes of one's action, becoming aware of one's feelings and how to manage stress and crisis situation, listening to others and speaking about depression and suicidal thoughts.

Some questions related to the effectiveness of e-treatment as opposed to in-class treatment. Professor Wassman stated that the group in-class work was more effective in her experience and that a particular aspect of a program such as YAM is that it is about social interaction. Interactions through Skype or other social media platforms couldn't necessarily provide this.

Professor Wassman also stated that again in her experience, there was no danger that it [YAMs] could trigger teenagers deciding to commit suicide—current studies all suggest otherwise that the program acts as an intervention to prevent suicide. Professor Wassman shared some data on the success of the YAM program and provided copies of the program to the delegation.

Public Health Agency of Sweden

The delegation was able to discuss broadly the health and mental health aspects of the Swedish health system with the Public Health Agency of Sweden.

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47 WHO mortality database (2017), OECD Family Database, CO4.4: Teenage suicides (15-19 years old), Updated: 17-10-17, www.oecd.org/els/family/database.htm

48 WHO mortality database (2017), OECD Family Database, CO4.4: Teenage suicides (15-19 years old), Updated: 17-10-17, www.oecd.org/els/family/database.htm

49 Selective serotonin reuptake inhibitors (SSRIs) are a class of drugs that are typically used as antidepressants in the treatment of major depressive disorder and anxiety disorders.

The delegation met with Dr Johanna Ahnquist, Head of Unit from the Public Health Agency and Ms Lidija Kolouh-Soderlund, Project Manager from the Nordic Welfare Centre. Dr Ahnquist told the delegation that the Swedish National Institute of Public Health, the Swedish Institute for Communicable Disease Control and parts of the National Board of Health and Welfare merged into a single agency in 2014 to form the Public Health Agency (the Agency). The Agency is considered a national expert authority, under the Ministry of Health and Social Affairs, with overall responsibility for prioritising public health issues.

Dr Ahnquist stated that the Agency's main roles are to:

- develop and support society's work to promote health, prevent illness and protect against health threats.
- offer a knowledge base and methodological support
- follow up and evaluate efforts by collecting and analysing data
- assume responsibility for national coordination within the area of disease control and within several other health-related issues such as alcohol, tobacco and narcotics, problem gambling and suicide prevention
- perform microbiological laboratory analysis and provide operational support during outbreaks
- promote international cooperation.

As such, most of the Agency's work entails liaising with government bodies from the local to the federal level and NGOs. Two critical pieces of work that it was commissioned to do and oversee national coordination of are:

- The *National Strategy Mental health 2016-2020, Five focus area for the next five years.* The Swedish Government has adopted a national strategy for mental health for the period 2016-2020. The strategy is based on five focus areas that have been identified as the main challenges when it comes to strengthening mental health and wellbeing and combating mental ill health.
- Working to implement the *National Action Program with nine strategies for suicide prevention*, adopted in 2008.

The delegation was told that the Agency divides this work up into three parts—coordination, knowledge and monitoring—on both these two initiatives.

Within the mental health space coordination involves:

- Participating in different collaborative groups/foras with stakeholders who actively work in promotion and prevention.

Within the suicide prevention space, coordination involves:

- Being responsible for coordinating groups of national agencies and authorities, as well as a national interest group of representatives from NGO's and researchers.

As initiatives are rolled out, the Agency monitors their implementation by:

- collecting data and performing epidemiological analyses;
- regularly presenting analysis of statistics and results in a way that is easily accessible for stakeholders; and
- mapping the suicide prevention work being carried out at local and regional levels.

And the third part of the Agency's work includes providing knowledge which in regards to suicide and mental health involves:

- systematic literature reviews on effective prevention interventions;
- a systematic literature review on the effects of pre-school on children's mental health;
- a study of the association between alcohol consumption[50] and suicide;
- a study of the situation of suicides in the Stockholm subway; and
- summaries of systematic reviews.

Aside from this work, the delegation heard that the Agency, like the National Board of Health and Welfare is responsible for allocation of some state grants, in this instance the grants are for preventative initiatives for both mental health and suicide prevention. The Agency is also commissioned by the government to further support local and regional efforts by allocating state grants for knowledge-building

Plan for suicide prevention among the Sámi people in Norway, Sweden and Finland

Ms Lidija Kolouh-Soderlund, Project Manager from the Nordic Welfare Centre, provided the delegation with a copy of the Plan for suicide prevention among the Sámi people in Norway, Sweden and Finland and a copy of the Young People in the Nordic Region—mental health, work, and education.

Ms Kolouh-Soderlund discussed the relationship the Nordic countries have with assisting the indigenous Sámi people who populate all the Nordic countries, more appropriately referred to as Sápmi— the cultural region traditionally inhabited by the Sámi i people. The delegation heard that the Plan for suicide prevention among the Sámi is the first plan and its strategies are based on the known available scientific knowledge about suicide and its causes as well as consultation with the Sámi. There is also an acknowledgement of the lack of knowledge about suicide and related health problems on the Russian side of the Sápmi which the Sámi also inhabit.

As ethnicity is not registered in Norway, Sweden or Finland, little is known conclusively about suicide in the Sámi. Several research studies have been undertaken with evidence that suggests suicide rates in the Sámi are higher than the domestic population and high proportionally for Sámi men as opposed to Sámi women which is consistent with many international findings regarding male suicide.

In line with the WHO's recommendation that encourages countries to establish national plans for suicide prevention, Sweden as part of the Nordic Council Ministers developed the plan in consultation with the Sámi Norwegian Advisory Unit on Mental Health and Substance Use and the Saami Council section in Norway, Sweden and Finland.

Young People in the Nordic Region—mental health, work and education.

Ms Kolouh-Soderlund also discussed another project called "Young People in the Nordic Region" which focuses on young people who suffer from or are at risk of suffering from mental ill-health, as well as examining their situation in school and later transition to work. Another important theme in this project is early retirement and invalidity pension due to mental ill-health among young people.

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50 In Sweden, the government controls all supply and sale of alcohol over a certain level of alcohol concentration.

The delegation was told that the project states that general youth policy investments in the culture, leisure, education and health sector are needed in all Nordic countries. Special investments for individuals and groups which risk isolation or mental ill-health are also required as is better detection of mental ill-health particularly among young boys. The delegation heard that young girls will state that they feel unwell to a greater extent than young boys, who will generally express their mental health by being involved in violence, abuse and resorting to other outwardly-directed aggressive behaviour.

Increasing mental ill-health among youth comprises one of the largest public health challenges faced by Nordic societies. The delegation heard that while working with this group it is important that there is a built-in flexibility and competence within the welfare sector to quickly determine who has a need and for which type of support, and so that the correct guidance and support can be provided.

Canada

Canadian health system

The Canadian health system (Medicare) is universal public insurance program largely administered and funded by the Provincial and Territory governments. Instead of having a single national plan, Canada has 13 Provincial and Territorial health care insurance plans. Under this system, all Canadian residents have reasonable access to medically necessary hospital and physician services without paying out-of-pocket expenses. In 2017, total health expenditure in Canada was expected to reach $242 billion, or $ 6,604 per person, representing an estimated 11.5% of Canada's gross domestic product (GDP).[51]

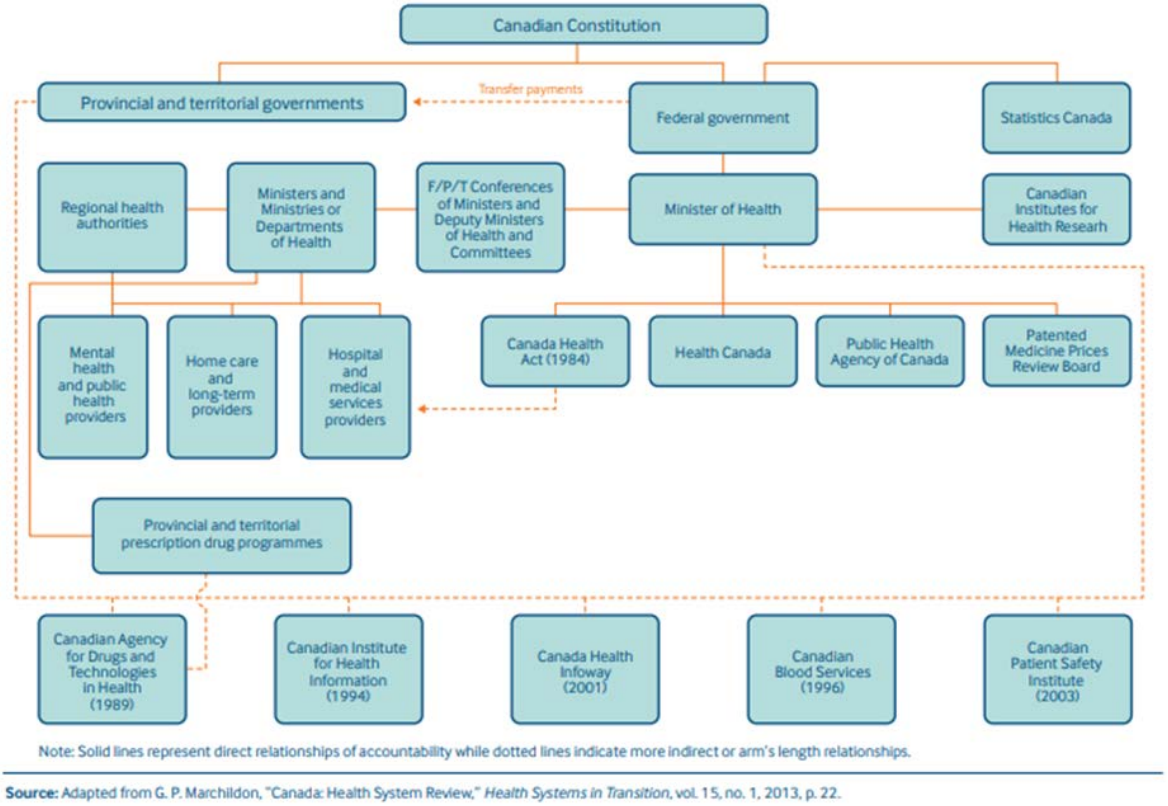

Diagram 4, Structure of Canadian health system

51 Canadian Institute for Health Information, https://www.cihi.ca/en/health-spending

Delegation Meetings

In the morning of Thursday, 5 October 2017, the delegation met with two of the House of Commons Standing committees, the House of Commons Standing Committee on Veterans Affairs, and the House of Commons Standing Committee on Indigenous and Northern Affairs, to exchange ideas and lean about how the Canadian committee system operates including issues of interest for each of the standing committees.

House of Commons Standing Committee on Veterans Affairs

The delegation's first meeting in Canada was with the House of Commons Standing Committee on Veterans Affairs where it discussed some of the veteran issues Canada has been facing. The issues raised reflect similar experiences for veterans within Australia, namely PTSD, return to work and issues related to the use of the anti-malaria drug mefloquine.

Meeting with the Standing Committee on Veterans Affairs

Interestingly, alcohol was one of the more significant issues facing the Canadian veteran population along with PTSD, which mirrors similar findings in the UK, the Netherlands and to a lesser extent, Sweden. The committee noted some specific issues that it thought were important for the government to take the lead on, for example, how employment for veterans could be incentivised by government to help address feelings of detachment and isolation amongst the veteran population.

Members of the committee spoke about the American GI Bill that provides free education for veterans and how they would like to do something similar in Canada.

The committee also spoke of the stigma of mental health in the defence forces and how there is still a policy of "one mental episode and you're out". This discourages soldiers from reporting any issues they may have. Some committee members noted that first responders in the emergency service are now looking to start a national strategy like the Canadian Armed Forces to deal with PTSD in their workplaces.

House of Commons Standing Committee on Indigenous and Northern Affairs

Following its meeting with the House of Commons Standing Committee on Veterans Affairs, the delegation met with the House of Commons Standing Committee on Indigenous and Northern Affairs. The delegation heard that many young indigenous youths see little hope in

the future. This despair has coincided in an elevation of suicides in both young indigenous girls and boys. Key issues are the ability to access suitable mental health services and access to quality housing.

Mr Romeo Saganash MP, a member of the New Democratic Party and a Cree national, one of the largest groups of First Nations in North America, provided a traditional welcoming to the delegation in Cree. Mr Saganash highlighted that while he spoke in Cree to us it was not a recognised language in law or the Parliament. He has been campaigning for a long time to ensure that any Canadians laws are in harmony with the United Nations Declaration on the Rights of Indigenous Peoples.

Mr Saganash also highlighted the intergenerational trauma that exists in first nation and indigenous people today and how difficult it is to detach children from this trauma. He also spoke of the injustices in the non-honouring of treaties and how important it was to address the findings of the Truth and Reconciliation Commission into residential schools—Mr Saganash was placed in a residential school for ten years as a youth.[52]

City of Ottawa Public Health Group

Mr Benjamin Leikin Supervisor Mental Health and Mr Marino Francispilla, Program Manager, Schools and Community Mental Health and Wellness, Ottawa Public Health Group (OPH) met with the delegation on Thursday 5 October 2017. Mr Leikin provided the delegation with an overview of the Ottawa mental health system, the roll of public health, OPH's strategy and the challenges facing its work.

Meeting with Public Health Group

Mr Leikin listed some of the current mental health issues facing the OPH, such as postpartum mothers reporting mental health concerns, young adults having mood and anxiety disorders, high school children reporting suicide ideation, alcohol misuse, drug overdose and suicides. The delegation heard that the main role of public health in mental health is a population health approach, health promotion, policy development and assessment and surveillance.

Mr Leikin informed the delegation that OPH has three main strategic focus areas which govern its program of work:

1. Mental health awareness and stigma reduction

- Internal, focused on improving OPH staff's mental health literacy
- External, (expansion of its public health campaign *'have THAT chat'*[53])

52 The Truth and Reconciliation Commission of Canada (TRC) was a Commission organised by the parties of the Indian Residential Schools Settlement Agreement. It was established 2 June, 2008 with the purpose of documenting the history and impacts of Indian residential schools. It provided former residential school attendees an opportunity to share their experiences during public and private meetings held across the country.

53 http://www.ottawapublichealth.ca/en/public-health-services/have-that-talk.aspx

2. A more resilient community

- OPH have a range of specific mental health programs for workplaces, caregivers, infants and schools
- Also have support for alcohol and drug abuse prevention[54]

3. Suicide prevention,

- SafeTALK, (training programs in suicide alertness to help people recognise a person with suicidal thoughts and connects them with suicide first-aid resources)
- Suicide Prevention Guideline
- Post Suicide Support Team,(parents lifeline – peer support)
- Working with media: OPH have been working with social media groups, facebook, twitter, snapchat and google on suicide awareness
- mental health courts have worked
- developing strategies for dealing issues around drug use

Finally, some of the challenges that OPH mentioned to the committee were long waiting times for all public funded programs, language barriers in a bilingual country, cultural consideration for health care particularly with the indigenous population's health considerations, and the high cost of entry for small private healthcare providers wanting to get started.

Friday 6 October 2017

Department of National Defence and Department of Veterans Affairs

On Friday morning, the delegation met with a number of representatives from the Canadian Armed Forces (CAF), the Canadian Forces Health Services (CFHS) and the Department for Veteran Affairs to discuss metal health in the CAF. Brigader General Andrew Downes, Surgeon General, Canadian Forces Health Services Group, and staff provided the delegation with an introduction on the CFHS and mental health services in the forces.

Brigader General Downes informed the delegation that the CAF through the CFHS directly provides out-patient care (except on operations), hospital care and many specialist services purchased from the civilian sector. The CFHS also undertakes education and training of personnel and conducts its own research program. All personnel are assigned to a Care Delivery Unit (CDU) for 'walk-in' or by appointment; all required prescriptions are also covered under these arrangements. All medical records of service personnel undertaken by the CFHS are electronic.

A Directorate of Mental Health exists within the CFHS that deals solely with mental health in the CAF. The Directorate has sections responsible for mental health education and training, supporting programs like the Canadian Mental Health Commission's *Road to Mental Readiness* (R2MR) resilience program, it also has a section devoted to clinical programs such as, suicide prevention, and it has a research and analysis section which links in with the Canadian Military and Veterans Mental Health Centre of Excellence.

Statistics Canada notes that at the individual [solider] level, mental disorders in the military are commonly associated with distress or disability, behavioural or psychological

54 Canada will soon be one of the first G7 countries to legalise marijuana in 2018, https://ottawacitizen.com/tag/marijuana-legalization.

dysfunction, pain, and sometimes death. For the military, these conditions have been identified as the leading causes of reduced productivity, absenteeism, and turnover.[55] The Directorate's focus is to understand conditions that affect CAF personnel through population health surveillance and research, educate and assist through education programs and training; while offering appropriate care and clinical services to CAF personnel.

While the delegation was in Canada, the Canadian Government released a statement announcing additional funding for Veterans Affairs Canada to promote greater awareness of mental health issues, including an investment in a new Centre for Excellence specialising in mental health and more funding to expand the CFHS's Medical Services Branch.

Presently, the CFHS has 36 clinics of which 31 have mental health clinics across Canada and Europe. They also have access to Veterans Affairs Canada Operational Stress Injury (OSI) clinics, private clinicians registered as mental health service providers (~1200) and in addition, patients can be referred to the civilian sector for in-patient services (crisis, addictions, etc) if required.

The delegation heard that OSI clinics provide care services to a group of diagnoses that are related to injuries that occurred as a result of operations. The most common OSIs are PTSD, major depression and generalised anxiety. CFHS states that this is done to help break down barriers to care and to reduce stigma surrounding mental illness. Whereas, the CAF's General Medical Health Program provides assessment and individual and group treatment for those suffering from mental illnesses, such as depression, anxiety or PTSD that are not attributed to deployed operations.

The CFHS shared a copy of their recently completed *2017 Report on Suicide Mortality in the Canadian Armed Force (1995 –2016).* Which found that while suicide is a significant mental health issue and is the second leading cause of death among people aged 15-34 in Canada, suicide rates in the CAF are no higher, and are in fact lower, than those in the general population of the same age and sex. From 1995 to 2016, there has been no statistically significant change in the overall suicide rate of CAF Regular Force males. The report also notes that the 'high prevalence of substance use disorder, mood disorders, spousal/intimate partner breakdown and/or of career-related proceedings may be indicators of heightened suicide risk in CAF Regular Force males.' There is also no increased rate of suicide among those who have deployed versus those who have not.[56]

Brigader General Downes also outlined some of the non-health service programs the CFHS conducts:

- Many workplace programs
  - Active career management and professional development,
  - Unit support, sick leave, return to work
  - Harassment policies, sexual misconduct response centre
- Operational Stress Injury Social Support
- Joint Personnel Support Unit

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55 Statistics Canada, Health at a Glance, Mental health of the Canadian Armed Forces, Caryn Pearson, Mark Zamorski and Teresa Janz, Catalogue no. 82-624-X, https://www150.statcan.gc.ca/n1/pub/82-624-x/2014001/article/14121-eng.htm

56 2017 Report on Suicide Mortality in the Canadian Armed Force (1995 –2016), p. 11.

  - support people through return to work or transition to civilian life
- Military Family Resource Centres
- Vocational rehabilitation and transition programs for veterans
- Chaplains

The CFHS provided the delegation with a number of publications that it has undertaken: Surgeon General's Integrated Health Strategy – 2017, Integration for Better Health; Surgeon General's Mental Health Strategy, Canadian Forces Health Services Group, An Evolution of Excellence and the 2017 Report on Suicide Mortality in the Canadian Armed Force (1995 –2016) this included a copy of the Canadian Armed Forces and Veteran Affairs Canada, The Joint Suicide Prevention Strategy, Annex.

Canadian Mental Health Commission

After meeting with the Canadian Forces Health Services in the morning, the delegation met with Mr Michel Rodrigues, Vice-President, Canadian Mental Health Commission (CMHCC) and staff. CMHCC noted that over the years they have worked very closely with Australia on many areas of mental health which has allowed both countries to share best practices and accelerate the development of tools, resources and speed up implementation and uptake.

Mr Rodrigues explained that Canada now has a national mental health strategy and an action plan nationally and for every Province too. Mr Rodrigues outlined the *National Standard of Canada for Psychological Health and Safety in the Workplace,*[57]the Standard is voluntary developed to assist employers protect and promote mental health and safety of employees in the workplace. MHCC developed an implementation guide and a set of tools and resources for employers to establish a framework to address mental health at work.

The delegation heard about other initiatives that CMHCC has developed or supported in Canada across the mental health spectrum including, housing, workplace mental health, help in reducing stigma of mental health, and indigenous mental health. The following are some examples of current work that CMHCC has done, more can be found on their website:

Anti Stigma programs for the workplace:

- The Working Mind (TWM) Workplace Mental Health and Wellness is an education-based program designed to address and promote mental health and reduce the stigma of mental illness in a workplace setting. (www.theworkingmind.ca)
- Road to Mental Readiness (R2MR),[58] this is TWM adapted to first responder populations. A key part of the R2MR is the 'Big 4', a set of cognitive behavioural therapy-based techniques to help individuals cope with stress and improve their mental health and resiliency. The Big 4 are positive self-talk, visualization, tactical breathing, and SMART goal setting.
- HEADSTRONG is another example of CMHCC's anti-stigma initiatives, aimed at young people and designed to challenge misconceptions about mental health problems and illnesses. Its slogan is *'Be Brave, Reach Out and Speak Up'* helps promote open

57 National Standard of Canada for Psychological Health and Safety in the Workplace, an international first, https://www.mentalhealthcommission.ca/English/national-standard.

58 Canadian Mental Health Commission, https://www.mentalhealthcommission.ca/English/document/36176/road-mental-readiness-r2mr-one-page-overview

discussion and helps highlight positive stories about recovery from community members with direct or indirect lived experience of mental illness.[59]

- As part of HEADSTRONG, #338 Conversations (which refers to the country's 338 federal ridings [federal electorates]) is a campaign to engage members of Parliament to lead conversations in their community about youth and mental health and to help introduce the HEADSTRONG program in their home regions. Toolkits were prepared by CHMCC and provided to parliamentarians to help organise meetings in their communities so that the community members can learn how the program helps dispel myths about mental illness which can halt recovery by preventing people from seeking help.[60]
- *Mental Health First Aid*, originally from Australia, CMHCC successfully adapted it for use with Inuit and First Nation populations in Canada.[61]
- *Housing First Toolkit*, this is a toolkit for Housing First based on At Home, (Chez Soi) it helps answer some of the questions that get asked about how to engage with landlords.[62]

Meeting with Health Canada and the Canadian Institute of Public Health

Health Canada and the Canadian Institute of Public Health

In the afternoon of 6 October 2017, the delegation met with representatives from Health Canada, the Canadian Institutes for Health Research and the Public Health Agency of Canada.

59 HEADSTRONG, https://www.mentalhealthcommission.ca/English/headstrong

60 #338 Conversations, https://www.mentalhealthcommission.ca/English/338conversations

61 Mental Health First Aid, https://www.mhfa.ca/en/course-type/inuit

62 Housing First Toolkit, http://www.housingfirsttoolkit.ca/

Centre for Health Promotion, Public Health Agency of Canada

Ms Stephanie Priest, Executive Director, Centre for Health Promotion, Public Health Agency of Canada (PHAC), gave the delegation an outline of the role PHAC plays in promotion and prevention efforts of national Canadian health policy.

Ms Priest discussed PHAC's public health focus for the Canadian population at both the individual and the community level. Ms Priest noted that the work encompasses a range of activities performed by all three levels of government (federal, provincial/territorial, and municipal) and includes strengthening intergovernmental collaboration on public health policy and planning. Examples that Ms Priest gave were: health promotion; prevention of and control chronic diseases and injuries; prevention of and control infectious diseases; preparing for and responding to public health emergencies.

Ms Priest made the point that good data collection is critical in underpinning any developing future government strategies like the Canadian mental health strategic plan 2017-2022. This is then supplemented with guidance on best practice delivery for interventions.

Ms Priest also spoke about suicide and eating disorders. In regard to suicide, Ms Priest noted that national suicide data had has not changed significantly from the long term average; however, what had changed was the level of indigenous youth suicide rates for Canada which have increased proportionally. Ms Priest noted that this example highlighted the need to better direct what granularity of data they need to collect to effectively manage the different risks? Ms Priest mentioned that data on eating disorders is slowly getting more attention though it still needs a lot more work.

Canadian Institutes of Health Research

Mr Steve Mitchell, Manager of Strategic Initiatives, Canadian Institutes of Health Research (CIHR), provided the delegation with background into the work the Institute undertakes

Mr Mitchell stated that the CIHRS main roles include:

- funding investigator-initiated research, and research into targeted priority areas;
- building research capacity in under-developed areas and training the next generation of health researchers; and
- focusing on knowledge translation that facilitates the application of the results of research and their transformation into new policies, practices, procedures, products and services.

An example of this work is the creation of the *Access Open Minds Network*, a national research and evaluation network to help transform youth mental health care across Canada. There are 14 *Access Open Minds* service sites across Canada in both urban and rural communities. Six of these are in Indigenous communities. Mr Mitchell noted that the fastest growing section of Canadian population is indigenous youth.

First Nation and Inuit Health Branch (FNIHB), Health Canada

Dr Thomas Wong, Chief Medical Officer, Public Health & Executive Office, First Nation and Inuit Health Branch (FNIHB), Health Canada provided the delegation with a copy of the *First Nations Wellness Continuum Framework.* The Framework focuses on the broader concept of mental wellness rather than mental illness. Dr Wong said that mental wellness is supported by factors such as culture, language, Elders, families and creation and it is in this spirit that FNIHB approaches mental wellness in the context of reconciliation.

Dr Wong talked about the impact of colonisation and mental health recognising the intergenerational trauma and the wide disparities in mental health outcomes, for example:

- gaps in health outcomes between Indigenous and non-Indigenous Canadians
- discrimination in the health care systems
- less access to the social determinants of health: education, employment, housing and food security
- higher rates of youth suicide and suicidal ideation
- higher rates of problematic substance use
- community crises relating to youth solvent abuse and suicide.

Dr Wong described the interplay between the federal role in health care, the Provinces and Territories, and the Indigenous people. Federally, Health Canada funds or directly provides health programs and services for First Nations and Inuit that supplement those provided by Provinces and Territories in the areas of:

- primary health care
- non-insured health benefits
- health infrastructure support

The Provinces and Territories provide universal insured health services (physician and hospital services) to all residents, including First Nations, Inuit and other Indigenous peoples. First Nations and Inuit are involved in directing, managing and delivering a range of health programs and services. An example of this was the devolution of control and finances in 2013 from the federal government to the First Nations Health Authority for the administration of health services for the province of British Columbia.

Dr Wong also highlighted the Canadian Prime Minister, the Rt Hon Justin Trudeau's Mandate letter to all Canadian Cabinet Ministers on 13 November 2015 stating "It is time for a renewed, nation to nation relationship with indigenous peoples based on recognition, rights, respect, cooperation and partnership."

Another significant milestone in Canada's reconciliation process has been the Calls to Action (CTA) recommendations resulting from the Truth and Reconciliation Commission's (TRC)[63] findings. As part of the TRC there are 11 health related CTAs dealing with a wide range of areas such as: implementing Jordan's Principle[64], parenting and early childhood education, establishing measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, traditional healing and increasing cultural competency in the healthcare system.

Dr Wong said that the challenges of health service delivery to indigenous populations are: highly diverse cultural groups (634 First nations and 53 Inuit communities); geographically isolated and often small in size; varying levels of community capacity and stability including unique health and social challenges; and that access to and integration with provincial health services is inconsistent. Dr Wong also spoke of the 2016 National Inuit Suicide Prevention

63 See footnote 49

64 Jordan's Principle makes sure all First Nations children can access the products, services and supports they need, when they need them. https://www.canada.ca/en/indigenous-services-canada/services/jordans-principle.html

Strategy developed by Inuit Tapiriit Kanatami (ITK) which Health Canada is supporting in its to implementation.

In summing up, Dr Wong mentioned some of the key learnings for Health Canada moving forward. The need to listen to Indigenous partners, acknowledge intergenerational trauma and the need for trauma informed care, continue to address the Indigenous social determinants of health, use a Strength-Based Lens [of greater self-determination], provide and support community-driven and community-based approaches to dealing with Indigenous issues including support holistic approaches particularly using culture as a foundation. Finally Dr Wong spoke of future opportunities for collaboration, specifically through support of Australia/Canada linkages between Indigenous Elder and Youth and to continue to support the Wharerātā Group—an international network of Indigenous leaders working in mental health and addictions.

Delegation members outside the doors to the Canadian Lower of House of Parliament

Privy Council Office

The delegation met briefly with Ms Catrina Tapley, Deputy Secretary to the Canadian Cabinet Privy Council Office. Ms Tapley explained what the Canadian government was doing in the Mental Health space and in particular it saw that there was a federal leadership role and was making it a priority across the Canadian public service to de-stigmatising mental health issues in the workplace. They do this through a range of supporting material including a campaign called 'Lets talk' to help the public service address mental health issues. Ms Tapley also mentioned that the Canadian Public service executives are now held responsible through their contracts for the mental health of workforce.

Indigenous Wabano Health Centre

Posting a wish/prayer at the Wabano Centre

The delegation was fortunate to end its time in Canada with a visit to the Wabano indigenous Centre for aboriginal health. The delegation met with Ms Gina Metallic, Circle of Care Coordinator, at the centre. Ms Metallic told the delegation that Wabano is the Ojibwe word meaning ‘new beginnings’. The Ojibwe, belong to the Anishinaabeg group of Indigenous peoples and are the second-largest First Nations population in Canada, surpassed only by the Cree. At Wabano, the goal is to create a place where new beginnings can happen for all Aboriginal people – Inuit, Métis and First Nations.

Ms Metallic explained that in the city, many Aboriginal people struggle to connect with culture and traditions, resulting in broken communities and poverty. At Wabano, she explained, situated in one of Ottawa's poorest communities, they are providing social, emotional and spiritual support.

By integrating Aboriginal and western health and wellness approaches, they have improved the outcomes for urban Aboriginal citizens who were falling through the cracks. The centre provides a space that can focus on healing and culture revitalisation while also providing traditional healing and scared medicines.

The centre has medical clinics (includes sexual health, diabetics clinic, general and mental health and maternal health), social services and support, and youth programs for Ottawa's Indigenous people. All services are based on implementing best practices for community health care, which also incorporate the teachings, culture, and traditions of Indigenous people.

Ms Metallic explained that the large circular hall that sits in the middle of the building is designed around the traditional medicine wheel which is intended to create belonging and culture as healing. The circle represents unity of all cultures and shows that we are all connected, all related. This circle concept is shared by First Nations, Inuit and Métis cultures.

The buildings four floors represent four elements:

- Earth: dark blue at the bottom of the logo (ground floor)
- Water: turquoise in the middle (maternal wellness and clinic floor)
- Fire: sun burst (cultural gathering space)
- Sky: rainbow segments at the top of the logo (social enterprise, mental health and outreach)[65]

The room is specifically for cultural business and group processes, it includes a men's circle, mediations for child and family welfare. It employs a strength-based approach to put the power back into families hands circle for safety planning for children.

65

Overall, the delegation found the Parliamentary Study Field Visit examining mental health issues and practices to be highly valuable and rewarding, particularly in understanding how other countries dealing with such diverse and difficult issues. The delegation would like to express its sincere appreciation to all those it met with, and for warm hospitality and willingness to share experinces and ideas on how to improve others lives.

Delegation Leader

Senator Rachel Siewert

Appendix A

Mental Health Individuals and organisations visited

London:

Tuesday 26 September

- Royal College of Psychiatrists:
  - Dr Jon Goldin, Consultant Child and Adolescent Psychiatrist, Department of Child and Adolescent Mental Health, Great Ormond Street Hospital and Holly Taggart the RCPsych Head of Policy and Campaigns, and Ms Zoe Mulliez, Policy and Campaigns Officer Accompanied by Duncan Howitt
- Institute of Psychiatry, Psychology & Neuroscience
  - Professor Ian Everall, Executive Dean, Institute of Psychiatry, Psychology & Neuroscience, King's College London
  - Dr Andre Danese, Senior Lecturer, MRC Social, Genetic, and Developmental Psychiatry (SGDP) Centre, King's College London
  - Professor Louise Howard, NIHR Research Professor, Head of the Section of Women's Mental Health, King's College London
- Southwark Wellbeing Hub, Together for Mental wellbeing,
  - Mr Leon White, Project Manager, Together for Mental Health, SLaM, 12 Old Street, Southwark

Wednesday 27 September

- NHS TIL Veteran's Mental Health Services:
  - Dr Alyssa Joye, Clinical Psychologist, NHS TIL Veteran's Mental Health Services, 4th Floor West Wing, St Pancras Hospital
- Royal College of Psychiatrists:
  - Dr Bernadka Dubicka, Chair of Child and Adolescent Faculty, Royal College of Psychiatrists, 21 Prescot Street
- South London and the Maudsley
  - Dr Mathew Patrick, CEO, South London and the Maudsley, 1st Floor, Admin Block, Maudsley Hospital
- King's Centre for Military Health Research
  - Professor Sir Simon Wessely, Co-Director, King's College Centre for Military Health Research, King's College

- King's Eating Disorders Research Group
  - Professor Janet Treasure, Co-Director, Eating Disorders Research Group, King's College
  - Professor Ulrike Schmidt, Co-Director, Eating Disorders Research Group, King's College
  - King's School Mental Health Study Group - Reach – Resilience, Ethnicity, and Adolescent Mental Health Study in schools.
  - Dr Gemma Knowles, Study Co-ordinator, Institute of Psychiatry, Psychology & Neuroscience, King's College London
  - Dr Stephanie Beards, Postdoctoral Researcher, Institute of Psychiatry, Psychology & Neuroscience, King's College London
  - Dr Charlotte Gayer-Anderson, Postdoctoral Researcher, Institute of Psychiatry, Psychology & Neuroscience, King's College London

Netherlands

Thursday 28 September

- Novarum
  - Ms Elske van den Berg, Managing Director, Novarum
  - Ms Elske van den Berg, Managing Director
- MEE Zuid-Holland Noord at Parkoers
  - Beadini de Vries, Coordinator Integrated Care, MEE Zuid-Holland Noord

Friday 29 September

- Dr Rene Keet, Medical Director, GGZ-Noord-Holland-Noord
- Ministry of Health, Welfare and Sport
  - Ms Daphne Dernison, Senior Adviser, Ministry of Health, Welfare and Sport
  - - Ms Daphne Dernison, Senior Adviser Bilateral Relations & Economic Diplomacy
  - - Ms Paulien Seeverens, Adviser on Mental Curative Care
  - - Mr Aarnout Melis, Policy Adviser Specialised Mental Health Care
  - - Ms Margré Jongeling, Policy Coordinator Compulsory Mental Health Care Act
  - - Ms Marinka Wildeman, Policy Adviser of the Social Support Department
  - - Mr Taoufik Abou, Policy Adviser International Affairs

- Roundtable discussion with members of the Netherlands' Senate Committee on Health, Welfare and Sport
  - - Ms Reina G. de Bruijn-Wezeman (liberal)
  - - Professor Paul Schnabel (centre democrats)
  - - Ms Marleen Barth (labour)
- Roundtable discussion with Trimbos Institute at Residence
  - - Rutger Engels, CEO Trimbos Institute
  - - Ionela Petrea, Head Department Trimbos International
  - - Laura Shiels, Project Manager and Research Associate
- Meeting with Association of Dutch Municipalities (VNG), Project Lead Sheltered Living Association
  - Mr Ico Kloppenburg, and staff

Sweden:

Monday 2 October

- Mandometer Clinic, KI Science Park
  - Dr Cecilia Bergh, CEO, Mandometer Clinic, KI Science Park Karolinska, University Hospital
  - Professor Per Sodersten, Mandometer Clinic, KI Science Park Karolinska, University Hospital
- Meeting with Swedish Parliamentary Committee on Health and Welfare
  - Ms Emma Henricksson, Chair of the Committee on Health and Welfare Member of the Riksdag Sveriges Riksdag
  - Ms Sultan Kayhan, Deputy Chair of the Committee on Health and Welfare Member of the Riksdag Sveriges Riksdag
- Meeting with the National Board of Health and Welfare
  - Ms Birgitta Lindelius, Head of Unit Socialstyrelsen
- Meeting with the Speaker of the Swedish Parliament
  - Mr Urban Ahlin, Speaker of the Swedish Parliament, Sveriges Riksdag
- Meeting with the Veteran Centre, Swedish Armed Forces
  - Sergeant Major Daniel Nybling, Department of Veterans Affairs Forsvarsmakten

Tuesday 3 October

- Meeting with KI Centre for Psychiatry Research (CPF) and site visit to the Child and Adolescent Psychiatry (BUP) research clinic
  - Ms Clara Hellner Gumpert, Head of Operations, CPF KI Centre for Psychiatry Research
  - Ms Yvonne von Hausswoolf-Juhlin, Medical Director, Associate Professor Stockholm Center for Eating Disorders
- Meeting with KI National Centre for Suicide Research and Prevention of Mental lll-Health (NASP)
  - Professor Danuta Wassman, Head & Founder NASP KI, National Centre for Suicide Research and Prevention of Mental lll-Health
  - Dr Vladimir Carli Senior Lecturer, KI National Centre for Suicide Research and Prevention of Mental lll-Health
- Meeting with the Swedish Association of Local Authorities and Regions & the Public Health Agency of Sweden

Canada:

Thursday 5 October

- Meeting with House of Commons Standing Committee on Veterans Affairs
  - Mr Neil R. Ellis, Chair, Standing Committee on Veterans Affairs House of Commons
- Meeting with House of Commons Standing Committee on Indigenous and Northern Affairs
  - The Honourable Maryann Mihchuk, Chair, Standing Committee on Indigenous and Northern Affairs House of Commons
  - Meeting with City of Ottawa Public Health Group, Meeting with Health Canada (First Nations And Inuit Health Branch), Public Health Agency of Canada
  - Mr Benjamin Leikin Supervisor Mental Health Ottawa Public Health Group
  - Mr Marino Francispilla, Program Manager, Schools &Community Mental Health and Wellness, Ottawa Public Health Group

Friday 6 October

- Roundtable meeting with Department of National Defence and Department of Veterans Affairs
  - Brigader General Andrew Downes, Surgeon General, Canadian Forces Health Services Group and staff
- Meeting with Canadian Mental Health Commission

- Mr Michel Rodrigue, Vice-President, Canadian Mental Health Commission and staff

- Meeting with Canadian Mental Health Association
  - Mr Timna Gorber Manager, Research & Economic Analysis Office of International Affairs, Public Health Agency of Canada
  - Dr Thomas Wong, Chief Medical Officer, Public Health & Executive Office, First Nation and Inuit Health Branch, Health Canada
  - Ms Stephanie Priest, Executive Director, Centre for Health Promotion, Public Health Agency of Canada
  - Mr Steve Mitchell, Manager of Strategic Initiatives, Canadian Institutes of Health Research
- Meeting with Privy Council Office
  - Ms Catrina Tapley, Deputy Secretary to the Cabinet Privy Council Office
- Meeting and tour of the Indigenous Wabano Centre for Aboriginal Health
  - Ms Gina Metallic, Circle of Care Coordinator, Wabano Indigenous Centre