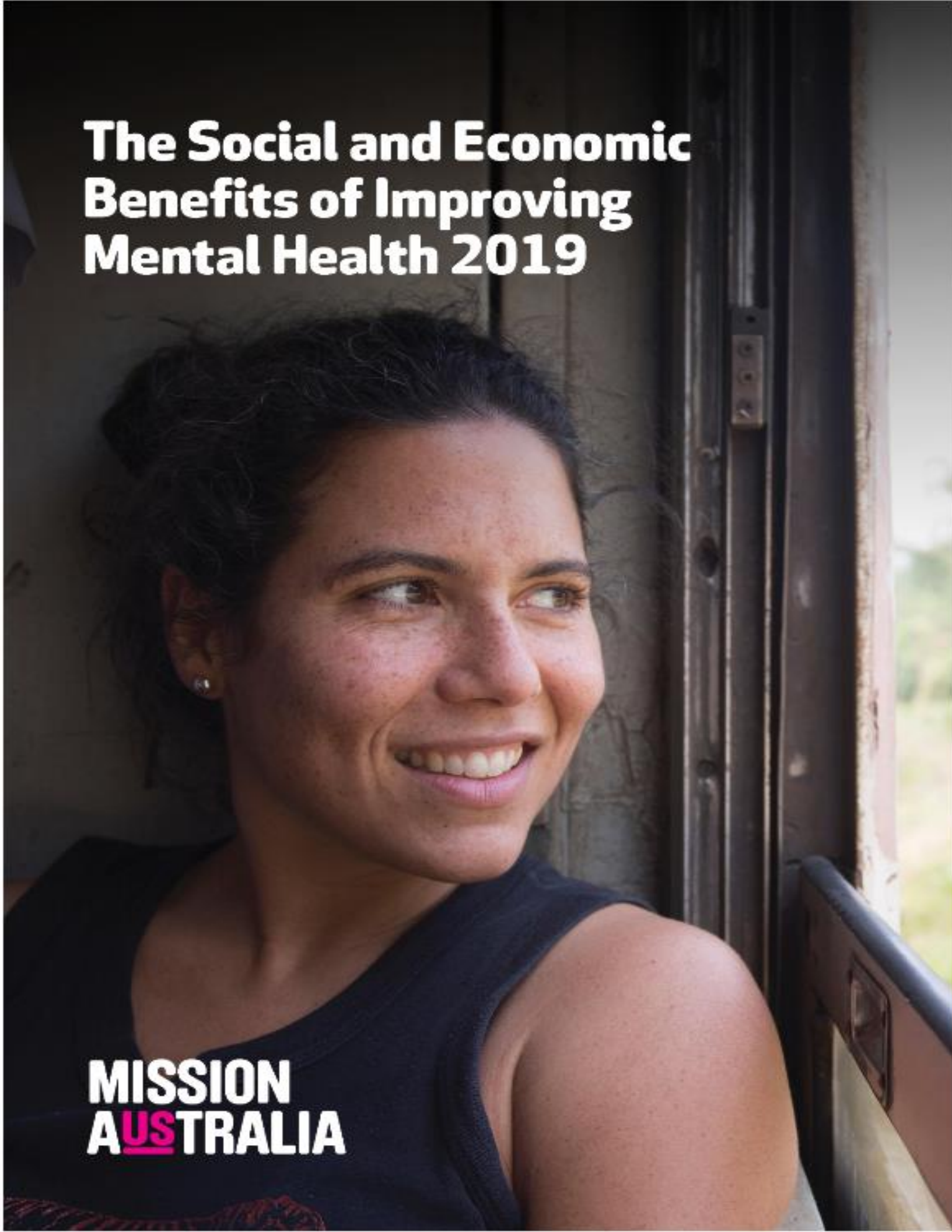
The Social and Economic Benefits of Improving Mental Health 2019



MISSION AUSTRALIA

The Social and Economic Benefits of Improving Mental Health

Introduction

Mission Australia is a national, non-denominational Christian charity that has been helping vulnerable Australians move towards independence for more than 160 years. In the 2017-18 financial year we supported over 120,000 individuals through 461 programs and services.[1] We supported over 10, 000 individuals through 45 mental health recovery related services.[2] In addition, the majority of other services such as domestic and family violence, housing and homelessness and alcohol and drug services provide mental health related supports to varying degrees.

Mission Australia welcomes the opportunity to provide input into the social and economic benefits of improving mental health. This submission is based on a combination of research and insights from our direct service provision across Australia. It includes direct testimony from some of our practitioners and the participants they work with.

Mission Australia believes that having access to the appropriate supports at the earliest possible point in time can assist people with mental health issues to recover and/or manage their conditions. Evidence and social return on investment evaluations demonstrate the financial effectiveness of various early intervention and community based mental health services. People with mental health issues significantly contribute to the Australian community and economy and it is important that these contributions are recognised and valued.

Recommendations

The Productivity Commission should recommend:

- A cross-sectoral and whole-of-government approach to mental health at a national level to coordinate the involvement of all the relevant portfolios and address underlying social determinants. This governance framework should also engage the community sector and people with lived experience from diverse backgrounds.
- A wide range of evidence-based universal mental health prevention and intervention programs should be made available and easily accessible. This will require additional government funding for schools or services to resource these programs.

[1] Mission Australia, Annual Report, 2018, accessible at: https://www.missionaustralia.com.au/publications/annual-reports/annual-report-2018/809-annual-report-2018/file

[2] Mission Australia, Service Delivery Census FY 2017/18.

- Access to culturally sensitive and age appropriate mental health services should be increased in Aboriginal and Torres Strait Islander communities including an increase in programs to prevent youth suicide.
- Increase support for successful peer support programs that will harness the human capital within rural communities, develop community capacity to address stigma associated with mental ill health and suicidality, and provide a valuable connection for people to engage with support services as well as increased employment opportunities for people who have experienced mental health issues.
- Successful mental health services that include access to housing, provide holistic, wrap-around supports in community and provide services to prevent social isolation, support to maintain tenancy and other ongoing support with education, employment and training should be replicated across the country.
- The social security payments such as Newstart, Youth Allowance and Disability Support Pension, Commonwealth Rent Assistance and other support payments should be increased to ensure people with mental illness are provided with adequate financial security.
- Increase mental health literacy through meaningful engagement and education that targets diverse cohorts such as Aboriginal and Torres Strait Islander people, CALD communities, LGBTI communities, women and people in rural and remote communities.
- Community based mental health services should be provided with additional supports to build relationships with local communities, complementary community services and the local communities through long-term sustainable funding.
- Employment services that provide specific supports to people with mental health issues should be equipped to understand the diverse range of mental health conditions, episodic nature of some of the illnesses and supported to negotiate flexible working conditions with employers.
- Greater efforts to divert people experiencing mental illness from coming to contact with the justice system and from imprisonment, including addressing the intersections between mental health and substance use, as well as supports to people with mental health issues on exiting prison.
- Mental health services should be co-designed with people with lived experience and carers and be based on evidence and research.

Consequences of mental ill-health

Mental health and many common mental disorders are shaped to a great extent by the social, economic, and physical environments in which people live.[3] Social inequalities, experiences of disadvantage and discrimination are all associated with increased risk of developing mental health issues. Experiencing these challenges over prolonged periods of time can escalate and cause significant mental health issues and have negative impacts on the individual, their family, friends and the community they live in.

Taking action to improve the conditions of daily life from before birth, during early childhood, at school age, during family building and working ages, and at older ages provides opportunities both to improve population mental health and reduce the risk of those mental disorders that are associated with social inequalities.[4] A meaningful framework to address these issues requires investment into a holistic approach that engages all levels of government, people from diverse backgrounds and lived experience and the community sector.

According to the Australian Bureau of Statistics there are over 4.8 million Australians with a behavioural or mental health condition and over 1 million people with psychosocial disabilities in Australia.[5] Furthermore, mental and substance disorders were the third largest disease burden in Australia and the largest disease burden for young people.[6] Timely provision of community based, holistic mental health services will result in meeting the needs of these individuals and thereby, reducing the cost of provision of acute mental health services and supporting people to live fulfilling lives.

Contributing components to improving mental health and wellbeing

The social gradient theory explains the relative disadvantage people experience from disadvantaged backgrounds. For instance, that people from low socioeconomic status (SES) areas tend to have worse health outcomes than those in the middle SES areas, who in turn have poorer health than those at the high SES areas.[7] Therefore, it is imperative that these inherent disadvantages experienced by people from low socioeconomic backgrounds should be addressed as a part of the broader strategy to improve mental health outcomes.

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[3] World Health Organization and Calouste Gulbenkian Foundation, Social determinants of mental health, Geneva, World Health Organization, 2014, accessible at: https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf?sequence=1

[4] Ibid

[5] Australian Bureau of Statistics, National Health Survey: First Results 2017-18, 4364.0.55.001, accessible at: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.001~2017-18~Main%20Features~Mental%20and%20behavioural%20conditions~70

[6] Australian Institute of Health and Welfare, Australian Burden of Disease Study: impact and Causes of illness and death in Australia 2011, 2016, accessible at: https://www.aihw.gov.au/reports/burden-of-disease/abds-impact-and-causes-of-illness-death-2011/contents/highlights

[7] S. Friel, Social determinants – how class and wealth affect our health, The Conversation, 2016, accessible at: https://theconversation.com/social-determinants-how-class-and-wealth-affect-our-health-64442

The World Health Organisation (WHO) defines the social determinants of health as the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.[8] The social determinants of health discourse clearly demonstrates how some health inequities are not caused by a lack of access to health services, but by the influence of inequalities in other sectors such as housing, occupation, education or income.[9] These social determinants of health provide a universal framework to build strong support systems to assist people with mental health issues, create a framework for social inclusion and economic participation. Thus, action on the social determinants of health involves the whole of society, but the health sector has a key role in moving towards health equity and championing inter-sectoral action.[10]

Lower social participation, pain and suffering, isolation and stigma and discrimination are likely to inflict more harm on individuals experiencing mental health issues and as a result their family and the broader community. If these challenges are unaddressed, these issues are likely to develop into significant mental health issues that will have social and financial implications for the society as a whole. Therefore, Mission Australia believes that comprehensive and cohesive mental health system should be underpinned by a social determinants of health framework.

Often the health portfolios of Federal and state and territory governments hold responsibility for mental health services. The above discussion demonstrates the importance of an inter-sectoral approach to achieving outcomes under the social determinants of health framework. Therefore, a cross-sectoral and whole-of-government approach should be resourced at a national level to coordinate the involvement of all relevant portfolios such as health, finance, youth, social services, justice, Indigenous affairs and the like in relation to mental health and the underlying social determinants of health.

Healthcare

The lack of adequate and sustainable funding to develop community-based services has meant people with lived experience and their families and carers have had limited access to services that would enable people with severe mental illness to live well in their community. Inability to access appropriate mental health services and early intervention can result in aggravating mental health conditions and require intensive supports such as hospitalisation or long-term assistance which is more expensive or has limited capacity to provide the requisite supports in a timely manner.

The Step-up, Step-down (SUSD) model is widely operated across Australia and is effective in supporting people in acute psychiatric inpatient units to be discharged into the SUSD and gradually transitioned to

[8] World Health Organisation, Social Determinants of Health, accessible at: https://www.who.int/social_determinants/sdh_definition/en/

[9] K. Rasanathan, E. Montesinos et al., Primary health care and the social determinants of health: essential and complementary approaches for reducing inequities in health, Community Health (2010). doi:10.1136/jech.2009.093914

[10] Ibid

returning home in a supportive manner.[11] The evidence demonstrates that this model is effective in reducing the pressure for acute care beds in hospital settings. For instance, it is estimated that the annual cost of an in-patient unit bed is nearly $300,000 whereas a recovery centre bed will cost less than $150,000. These demonstrate the financial benefits of increasing more community-based recovery support models.[12]

Mental health promotion, prevention and early intervention

Limited education and understanding about mental health issues increases the risk of conditions developing into more severe issues. This lack of mental health literacy also contributes to stigma, reluctance to seek help, and misunderstandings about mental health services.[13]

Provision of appropriate prevention and early intervention supports can reduce the cost of providing intensive mental health services in hospital or other acute care facilities.[14] In addition to the cost, the services offered in hospital settings may not meet the needs of people with mental health issues. Previous personal experiences or experiences of others with mental health treatment facilities can cause individuals to refrain from seeking clinical mental health supports.

> "Some people who were in institutions feel that medication was the only method of care available. Negative experiences can make people mistrust the medical system … In small communities, people talk and word gets around about one person's experience and everyone will have that negative impression of the whole mental health sector."
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> Mission Australia, Area Manager NSW

A recently released report indicated that nationally 90% of the Emergency Department (ED) patients left within 7 hours on average, but for people presenting with acute mental health crises this figure was 11.5 hours.[15] It was reported that this cohort of people were more likely than other patients to leave the ED prior to their treatment being completed, i.e. at their own risk and against medical advice.[16] The report also identified that there is a significant lack of community mental health services to prevent people with mental illnesses resorting to access the ED.[17] Considering the high cost of providing services at the

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[11] Mental Health Coordinating Council, Mental Health Matters: Future investment Priorities for NSW, 2018, accessible at: http://www.mhcc.org.au/wp-content/uploads/2018/11/MH-Matters-Future-Investment-Priorities-for-NSW.pdf

[12] Ibid

[13] A. Jorm, Mental Health Literacy: Empowering the Community to Take Action for Better Mental Health, American Psychologist, Advance online publication, 2011, accessible at: http://www.tips-info.com/wp-content/uploads/2011/12/mental-health-literacy-ap-in_press.pdf

[14] NSW Mental Health Commission (2014). Living Well: A Strategic Plan for Mental Health in NSW. Sydney, NSW Mental Health Commission, accessible at: https://nswmentalhealthcommission.com.au/sites/default/files/141002%20Living%20Well%20-%20A%20Strategic%20Plan%20(1).pdf

[15] Australian College of Emergency Medicine, The Long Wait: An Analysis of Mental Health Presentations to Australian Emergency Departments, October 2018, p.2.

[16] Ibid

[17] Ibid

ED, it would be financially beneficial to understand the person's individual circumstances and ways of meeting those needs through local community mental health services.

Suicide prevention

Suicide is the leading cause of death among people 15-44 years of age and remains the leading cause of premature mortality in Australia. In 2017, suicide deaths occurred at a rate of 12.6 deaths per 100,000 people.[18] In addition to mental health conditions, a range of emotional and environmental causes such as feelings of rejection and loss, academic pressure or experiences of bullying, abuse and neglect, and alcohol and drugs dependence can be factors behind suicide.[19]

A person does not need to be experiencing a diagnosable mental illness in order to consider suicide.[20] Therefore, services and supports need to be broad enough in scope to capture people with suicide ideation and a history of mental health issues or self-harm as well as equip people with information in relation to the supports available in instances where individuals experience a trigger event.

It is also estimated that for every death by suicide, as many as 30 people attempt to end their lives.[21] In addition to supporting people with suicide ideations, targeted after care and crisis care must be available to those who have previously attempted to end their life. The support services must have mechanisms to engage the person's family members, peers and the community to ensure that these people receive the necessary supports.

Exposure and Impact of Suicide

Measures adopted to address and prevent suicide should also focus on people who have witnessed or are affected by suicide within their family or community. In addition to the grief and trauma of learning that a loved one has died by suicide, the family members and friends may experience feelings of guilt, anger, confusion and distress.[22] The concept of 'suicide contagion' or 'suicide clusters' refers to the process whereby one suicide or suicidal act within a school, community or geographic area increases the likelihood that others will attempt or die by suicide.[23] These risks are more prevalent or heightened

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[18] Australian Bureau of Statistics, Suicide in Australia, 3303.0 - Causes of Death, Australia, 2017, accessible at: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Media%20Release~Alcohol-induced%20deaths%20decreasing%20over%20time%20(Media%20Release)~6

[19] R. M. Homes and S. Homes, Suicide: Theory, Practice and Investigation, Youth and Suicide, 2005, Ch. 4, p. 39 – 50.

[20] Education and Health Standing Committee, Parliament of Western Australia, *The impact of FIFO work practices on mental health Final Report*, 2015, p.2.

[21] Lifeline, Statistics on Suicide in Australia, accessible at: https://www.lifeline.org.au/about-lifeline/lifelineinformation/statistics-on-suicide-in-australia

[22] Healthy Place, Effects of Suicide on Family Members, Loved Ones, accessible at: https://www.healthyplace.com/suicide/effects-of-suicide-on-family-members-loved-ones/

[23] Headspace: School support, Suicide Contagion: Fact sheet, accessible at: https://www.headspace.org.au/assets/School-Support/Suicide-contagion-web.pdf

among young people. Recently, suicide clusters were identified in Mandurah WA[24] and Grafton in NSW[25] where several young people died by suicide within a short span of time. Considering the risk factors, it is imperative that practical and immediate preventative measures focus on early detection and provision of timely, community and early intervention services.

Preventing suicide among Aboriginal and Torres Strait Islander young people

Recent reports demonstrated that WA, QLD and SA had the highest Indigenous youth suicide rates.[26] Aboriginal children as young as 10 years dying by suicide has caused national alarm and the communities and sector organisations are calling on the Federal and State governments to adopt immediate measures to address these issues as a matter of priority. More needs to be done to provide the requisite supportive framework to prevent suicide. Thus, there is an urgent need for all levels of government to work with the community, particularly, Aboriginal and Torres Strait Islander people, their representative organisations, and other relevant community and government organisations to take urgent action to provide culturally appropriate suicide prevention related supports.

The Mission Australia Youth Survey 2017 investigated young people's mood and wellbeing by using the Kessler 6 (K6) questionnaire, which is a mainstream assessment tool that can be used to help diagnose generalised psychological distress, optimally in combination with sensitive questioning and a broader understanding of a client's situation. Based on their responses to this scale, nearly a third (31.3%) of Aboriginal and Torres Strait Islander respondents indicated some form of distress, compared to 24.2% of non-Indigenous respondents.[27]

The recent federal budget announced that the government will commit $5 million over four years from 2019-20 to implement Indigenous suicide prevention initiatives.[28] These are expected to be led by local youth Indigenous leaders to ensure that support is culturally appropriate and tailored to meet the specific needs of affected communities.[29] While more investment is no doubt needed, this level of funding is inadequate to respond to the gravity and the impact of Indigenous youth suicide.

The increase of youth suicide across Australia is a clear indication that more concrete and effective measures are needed to address these issues. These measures should include early intervention, eliminating stigma, education, awareness raising about the existing services and avenues of support.

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[24] R. Fenner, Mandurah community reeling after six teenage suicides, Mandurah Coastal Times, 11 April 2016, accessible at: http://www.communitynews.com.au/mandurah-coastal-times/news/mandurah-community-reelingafter-six-teenage-suicides/

[25] T Bowden, Youth suicides: Grafton community calls for help over lack of mental health resources in ABC News, 9 March 2017, accessible at: http://www.abc.net.au/news/2017-02-06/grafton-locals-call-for-help-over-youth-suicides/8243618

[26] NITV, Indigenous youth suicide at crisis point, 15 January 2019, accessible at: https://www.sbs.com.au/nitv/article/2019/01/15/indigenous-youth-suicide-crisis-point

[27] Mission Australia, Aboriginal and Torres Strait Islander Youth Report 2017, 2018, accessible at: https://www.missionaustralia.com.au/publications/youth-survey

[28] The Treasury, Budget Measures Budget Paper No. 2 2019-20, p.155 accessible at: https://www.budget.gov.au/2019-20/content/bp2/download/bp2.pdf

[29] Ibid

Addressing the social disadvantages experienced by Aboriginal young people, (including higher rates of incarceration, higher rates of child protection intervention, unemployment, housing stress) is an essential cornerstone in combating Aboriginal youth suicide. It is also essential that local communities are respected as experts in their own needs and ways to resolve their needs and are engaged with in a meaningful way in order to design, implement and deliver programs and services to address local needs.

Gift of Gallang

The Gift of Gallang (GoG) is a school-based wellbeing program for Aboriginal and Torres Strait Islander children in the Inala region (Grades 4-6). The program has a strengths based approach with a focus on healing mind, body and spirit. Program development occurred after a need for a suicide prevention program was identified by key community groups and Mission Australia. The wellbeing of individuals, families and communities had been significantly impacted by several deaths by suicide of Aboriginal and Torres Strait Islander children and young people. Concern was held that additional suicide attempts may have occurred as children as young as 8-11 years of age had expressed suicide ideation.

In order to foster resilience and wellbeing, GoG was designed with the local Aboriginal and Torres Strait Islander community in Inala through the formation of the Committee of Hope and supported by Mission Australia and Inala Wangarra. Committee members consisted of Aboriginal and Torres Strait Islander community members from Inala including staff from local community service organisations, Queensland Health and community Elders. The Committee of Hope worked in consultation with the former Cultural Connect Worker with Mission Australia, currently Community Resource Officer with Inala Wangarra to develop the overarching purpose of the program as well as contributing to the content and format of the program.

Consultation began in late 2015 and after considerable collaboration, the program ran for the first time this year across Term 2 in a local primary school. The program duration was for one hour across nine weeks with content aiming to provide students with strategies to foster social and emotional wellbeing, as well as a strong connection to community and culture. The facilitators that delivered the sessions were local Aboriginal and Torres Strait Islander community members, purposefully selected by the Committee of Hope.

Mission Australia is currently completing an evaluation of GoG to determine facilitators and barriers to the consultation process and if program goals were met. Initial reported outcomes have been positive, including a high engagement of students with the program, as well as increased community connections. Another recognised strength is that the consultation and development process has allowed ownership of the 'Gift of Gallang' to rest with the local Aboriginal and Torres Strait Islander community of Inala, Queensland. This evaluation report will be released later this year.

Financial pressure and unemployment

Suicide prevention strategies must focus on addressing a range of factors including assisting people who are experiencing financial pressure. Studies have indicated that financial pressure had the largest impact

on attempted suicides across all age groups.[30] Financial pressure can lead to family breakdown, increased violence within families and can have detrimental impacts on mental health.[31] Unemployment has a significant negative impact on physical health and mental health as it contributes to, or accentuates these negative health impacts that can result in increased rates of suicide and mental illnesses.[32] Unemployment and poor educational outcomes may also impact on self-esteem and lead people to feel that they are a burden to the society.[33]

Employment can provide people with a sense of purpose and value as well as an opportunity to interact with other people.[34] Therefore, additional supports should be made available to people experiencing financial pressure and information about such services should be communicated widely. Further, the financial pressure resulting from inadequate income support payments needs to be addressed as a priority as set out in the income support section below.

Rural and Remote communities

People living in rural areas experience a higher prevalence of deprivation, generally higher rates of social disengagement, the highest rates of service exclusion, and higher rates of economic exclusion compared to those living in inner cities.[35] Timely diagnosis, treatment and ongoing management of a mental health condition in rural and remote areas is likely to occur later or not at all, often resulting in an increased likelihood of hospitalisation and sometimes leading to the most tragic of outcomes - self-harm and suicide.[36] Deaths by suicide for those living in remote and very remote areas are almost twice as high as those living in major cities.[37]

Concerningly, rates of self-harm and suicide increase with remoteness suggesting that there are significant mental health issues to be addressed in rural and remote areas.[38] These figures demonstrate that people living outside a major city may be exposed to a unique set of structural, economic and social factors that result in poorer mental health outcomes and increased risk of suicide.

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[30] Y. Wang, J. Sareen, T. Afifi, S. Bolton and E. Johnson, Recent stressful life events and suicide attempt in Psychiatric Annals, 42.3, 2013, 101-108.
[31] Relationships Australia, August 2015: Impact of financial problems on relationships, accessible at: https://www.relationships.org.au/what-we-do/research/online-survey/august-2015-impact-of-financial-problemson-relationships
[32] Australasian Faculty of Occupational & Environmental Medicine, Australian and New Zealand Consensus Statement on the Health Benefits of Work Position Statement: Realising the Health Benefits of Work, 2014, p.12
[33] Boystown, Preventing Suicide by Young People: Discussion Paper, 2015, p. 10, accessible at: https://www.yourtown.com.au/sites/default/files/document/BT-Discussion-Paper-Prevention-of-Suicide-byYoung-People.pdf
[34] See further: Social Ventures Australia, Fundamental principles for youth employment, 2016, p.18
[35] Australian Institute of Health and Welfare, *Australia's Welfare 2017,* July 2017, accessible at: https://www.aihw.gov.au/getmedia/088848dc-906d-4a8b-aa09-79df0f943984/aihw-aus-214-aw17.pdf.aspx?inline=true
[36] National Rural Health Alliance, Mental health in rural and rural Australia. Fact Sheet, 2017, Accessible at: http://ruralhealth.org.au/sites/default/files/publications/nrha-mental-health-factsheet-dec-2017.pdf
[37] Australian Institute of Health and Welfare, Rural and Remote Health, May 2017, p.1.
[38] National Rural Health Alliance, Factsheet: Mental Health in Rural and Remote Australia, December 2017, accessible at: http://ruralhealth.org.au/sites/default/files/publications/nrha-mental-health-factsheet-dec-2017.pdf

Lifespan Integrated Suicide Prevention Program[39]

Lifespan Integrated Suicide Prevention program developed by the Black Dog Institute, the Centre of Research Excellence in Suicide Prevention and the Mental Health Commission of NSW adopted an innovative and inclusive approach to suicide prevention.

This model involves nine strategies for suicide prevention, including aftercare and crisis care, psychosocial and pharmacotherapy treatments, frontline staff training, school programs, community campaigns and media guidelines. This is being rolled out across 4 sites in NSW, namely, Newcastle, Illawarra, Central Coast and Murrumbidgee.

Evidence based suicide prevention programs should be replicated across the country with necessary financial and human resources.

Comorbidities

Current data indicate that the majority of the 1,045,900 people who reported a psychosocial disability reported having one or more other impairments or restrictions (87.4%).[40] Two-thirds (66.2%) of those people with more than one impairment or restriction had a physical disability.[41] These statistics demonstrate the need to better understand the individual needs and to ensure that the services supporting people with physical disabilities do not operate in silos.

Alcohol and drug dependence and mental health

It is generally accepted that people with mental health issues are particularly vulnerable to alcohol and drug dependencies and those with alcohol and drug dependency issues are also vulnerable to developing mental health issues.[42] This is substantiated by the evidence from service delivery experience through various alcohol and drug rehabilitation and detoxification facilities. For example, Mission Australia's Triple Care Farm Withdrawal Service and Rehabilitation Program supports people to overcome alcohol and drug dependence.

During the 2018 financial year, 62% of young people accessing Triple Care Farm services indicated that they had a history of suicide ideation and in 2017 this rate was as high as 83%. In addition, the number of young people presenting for alcohol and drug treatment with a co-occurring mental illness has also grown significantly from 78% in 2012 to 95.3% in 2018. This demonstrates the intrinsic link between

[39] Lifespan, Integrated Suicide Prevention, accessible at: http://www.lifespan.org.au/

[40] Australian Bureau of Statistics, Psychosocial disability, 4430.0 - Disability, Ageing and Carers, Australia: Summary of Findings, 2015, accessible at: https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4430.0Main%20Features902015?opendocument&tabname=Summary&prodno=4430.0&issue=2015&num=&view=

[41] Ibid

[42] See further: R. Shivani, J. Goldsmith and R. Anthenelli, Alcoholism and Psychiatric disorders: diagnostic challenges, Alcohol Research & Health, 2002, Vol. 26(2), pp 90-98.

alcohol and drug dependence and mental health and the need for more residential support services that provide wrap-around services, particularly for young people.

In 2015 Social Ventures Australia conducted a *Baseline Social Return on Investment (SROI)* analysis of Triple Care Farm.[43] The analysis highlights that that between 2009 and 2013 TCF provided treatment and care to 370 young people and in total Triple Care Farm's activities generated approximately $39.5M in value for its stakeholders across a range of outcomes. The analysis further stated that, when the total investment in Triple Care Farm between 2009 and 2013 is compared to the total social and economic value created, for every $1 invested into Triple Care Farm, approximately $3 of value was created.

There is increasing evidence that integrated treatment models which have the capacity to address both mental illness and substance dependence are both feasible and effective.[44] Therefore, it is imperative that there is better recognition of comorbidity and coordination between services, particularly mental health and alcohol and drug rehabilitation services.

Health workforce

In order to deliver effective services to people experiencing mental health issues, it is vital to have a qualified and experienced health workforce. Given the complexity of issues experienced by people, the workforce should have access to adequately funded multidisciplinary training.

Understanding these needs for a specialised and skilled workforce, the NSW government recently introduced a scholarship scheme for staff members who are engaged in the Housing and Accommodation Support Initiative (HASI) and HASI plus. Although funding was limited to train a small number of staff members, it was encouraging to note that the government is recognising the need for qualified staff in mental health service delivery.

Housing and Accommodation Support Initiative (HASI) Plus

HASI Plus is a supported accommodation program providing housing, daily living support and clinical care for people with lived experience of mental illness.

HASI Plus is a program specifically for people with severe and persistent mental illness who are ready to transition back to community living after long periods of stay in psychiatric facilities or similar institutions. HASI Plus provides 24/7 hour support to people who would otherwise be unable to successfully live independently.

[43] Social Ventures Australia, *Social Return on Investment (SROI) analysis of Triple Care Farm*, May 2015, accessible at: https://www.missionaustralia.com.au/publications/research/young-people-research/382-triple-care-farm-baseline-social-return-on-investment-analysis

[44] M. Deady, M. Teeson, K. Mills, et al, One person, diverse needs: living with mental health and alcohol and drug difficulties, A review of best practice, Sydney: NHMRC Centre of Research Excellence in Mental Health and Substance Use, 2013.

HASI Plus is strongly based upon the principles of recovery in which we foster hope, empowerment and self-determination in all aspects of our work. Day to day we provide hands on support and structure to teach wellbeing in daily living skills such as cooking, cleaning and budgeting; mental and physical health; community engagement and the ultimate recovery goal of one day all of our consumers being able to return to independent living.

There are stark differences in terms of staffing levels in major cities and remote and very remote areas. In 2015 there were nearly 16 (full time equivalent) Psychiatrists per 100,000 people in major cities compared to 2.1 in very remote areas. In major cities there were 90.4 (full time equivalent per 100,000 population) mental health nurses and only 31.6 in very remote areas.[45] This highlights that immediate measures are needed to increase access to a range of mental health services and professionals in these areas.

In rural and regional areas where there is a lack of mental health services, with resources spread very thinly across large geographic areas, significant mental health issues may go undetected and underdiagnosed leading to more unfortunate outcomes such as self-harm or suicide.

The shortage of trained and skilled workforce in rural and remote areas as well as the difficulties in retaining staff have been discussed at length through various inquiries, research and reports.[46] However, the issues persists and more work is required to ensure a qualified workforce in rural and remote areas.

> "Workforce is a big issue in our areas. Pilbara [WA] has a population of about 50,000 people scattered over a large geographic area and there's only one suicide prevention worker for the whole Pilbara area."
>
> Mission Australia, Program Manager WA-

A report produced by the Northern Territory Mental Health Coalition indicated that lack of 'pull-factors' and increased costs of housing and travel makes recruiting mental health professionals to rural and remote locations a major challenge which results in limiting the range of interventions available.[47] The report also identified the inequity in pay-scales between the not for profit sector and state/Commonwealth government departments and agencies as a factor in losing skilled staff to government positions.[48]

[45] Australian Institute of Mental Health, Mental Health and welfare, Mental health workforce, 2015, p.2 accessible at: https://www.aihw.gov.au/getmedia/39ef59a4-4bb3-4f90-b117-29972245ca95/Mental-health-workforce-2015.pdf.aspx

[46] See further: Government of WA, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, 2012, accessible at: https://www.health.wa.gov.au/publications/review/main_documents/mental_health_summary_2012.pdf

[47] Northern Territory Mental Health Coalition, *Mental Health & Suicide Prevention Service Review*, 2017, p. 47.

[48] Ibid p.10

> "Not many people want to live in areas where the conditions are harsh no matter what incentive you provide unless they are really passionate about what they do."
>
> Mission Australia, Cultural Officer – Townsville QLD

Some communities rely on medical and allied health professionals who visit intermittently, or who are on short term contracts, which affects continuity of care and means that people have to regularly rebuild rapport with different professionals. The long waiting periods to obtain appointments with mental health professionals can result in significantly deteriorating mental health or discourage people from seeking help.

> "In areas where local help is minimal, people have to wait for weeks to see a GP. It's much worse if you need a specialist professional like a psychiatrist."
>
> Mission Australia, Area Manager NSW

In addition to the challenges of having limited health professionals, the vast distances and scattered populations in rural and remote areas make it difficult for community organisations to deliver mental health services in rural and remote areas.

Rural and remote areas of Australia have low levels of public transport access. Some remote areas have relatively low levels of vehicle ownership.[49] In outer-urban areas transport disadvantage is the result of a range of intersecting factors including poor public transport infrastructure, a higher proportion of low-income households and the need to travel further distances in order to get to places of employment, services and activities.[50]

Travelling between services where there are staff shortages is not a viable option in many areas. For example, in certain regions travel distances between towns can range from 5 to 7 hours, and therefore, it is not feasible for staff to travel to other areas to deliver services.

> "Currently we have staff members who are willing to travel between different service areas if there is a staffing issue. It may not be possible in other remote areas where travel times are excessive."
>
> Mission Australia, Area Manager NSW

Additional incentives may be required for current employees in the community sector to remain in rural, regional and remote areas. Upskilling and reskilling those have lived experience through a peer work framework may also assist to address the staff shortage issue through the creation of a peer workforce.

[49] Australian Institute of Family Studies, *the relationship between transport and disadvantage in Australia*, 2011, p.1
[50] Ibid

Housing, income support and social services

There is an intrinsic link between mental health, housing stability, homelessness, poverty, alcohol and drug dependence, domestic and family violence and social supports. The supports need to be tailored to address the intersectionality of these challenges.

Housing and homelessness

People with mental illness have a right to live in safety and with stability, and to choose where they want to live, with whom, and the amount of support they require.[51] People with mental health issues are a group who are particularly vulnerable to homelessness, and can be isolated, have disrupted family and social networks and sometimes suffer poor physical health, all of which impacts their capacity to find and maintain adequate housing.[52] Several studies suggest that when people with mental health issues are supported by homelessness agencies, they are more likely to remain housed rather than return to homelessness.[53]

Of over 288,000 people accessing Specialist Homelessness Services (SHS) last financial year, over 81,000 indicated that they were experiencing mental health issues.[54] Mental health services, including psychological, psychiatric and mental health services, were one of the most common specialised services identified as needed by clients accessing SHS services, however, these needs were frequently unmet with around 3 in 10 clients (32%) neither provided nor referred to these services.[55]

There are various effective accommodation models such as housing first models that provide holistic supports to people with disabilities, including those with mental health issues, alcohol and drug related issues and a range of other complex needs which should be expanded and replicated such as the MISHA Project as well as HASI, HASI plus and Enhanced Adult Community Learning Service (EACLS).

Michael's Intensive Supported Housing Accord (MISHA Project) NSW[56]

The MISHA project was a successful Housing First model providing holistic care to men who were chronically homeless. It began in late 2010 with the aims of providing homeless men with support to

[51] S. Sowerwine, and L. Schetzer, Skating on thin ice: Difficulties faced by people living with mental illness accessing and maintaining Social Housing. Sydney, Public Interest Advocacy Centre, 2013.
[52] See further: Homelessness Australia, States of being: Exploring the links between homelessness, mental illness and psychological distress: an evidence based policy paper, 2011 and NSW Mental Health Commission, Living Well: A Strategic Plan for Mental Health in NSW. Sydney, NSW Mental Health Commission, 2014.
[53] Ibid
[54] Australian Institute of Health and Welfare, Specialist Homelessness Services Annual Report 2017-18, 2019, accessible at: https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-2017-18/contents/contents
[55] Ibid
[56] See further: Mission Australia, *From Homelessness to Sustained Housing, 2010 – 2013, MISHA research report*, accessible at: https://www.missionaustralia.com.au/documents/279-from-homelessness-to-sustained-housing-2010-2013-misha-research-report-2014/file

enter and sustain permanent housing, ensuring access to mental and physical health supports, reducing social isolation and equipping clients to live successfully within the community.

As a result of services provided, 98% of clients were able to support their tenancy over a 12 month period. Research on the project from 2010-2013 demonstrated costs associated with use of health and justice services were more than halved over 2 years – delivering a saving to government of more than $8000 per person each year.

Overall financial savings to government attributed to the MISHA Project were estimated at close to a million dollars over 2 years, through fewer nights spent in hospitals, mental health facilities or drug and alcohol centres, fewer visits from justice officers, less police interaction and less time spent in detention facilities.

There were also savings generated to housing providers due to reduced evictions, estimated at $1,880 per client, in the first 12 months of the client being housed. The total net saving to housing providers generated by providing tenancy support services to 74 MISHA clients over a one year period was estimated at $138,880.

Evidence from this model demonstrate that they are effective in increasing wellbeing and has significant positive financial benefits to the government. There are numerous models similar to MISHA that provide a range of wrap-around holistic supports to people who experienced homelessness with long-term complex needs.

HASI, HASI plus and EACLS type services provide wrap around holistic supports to people with psychosocial disabilities, through qualified and trained mental health staff members working with individuals to meet all their needs within the program and refer on to other programs where necessary.

Case study

Kate* a 62 year old woman, who had been in a psychiatric hospital unit for more than 2 decades. She started receiving coordinated supports from Mission Australia's HASI Plus in 2014. Since that time Kate was able to achieve a number of goals she intended to achieve for her health and wellbeing. These included losing 20kg of weight, quitting smoking after 40 years, improving her daily living skills and increase in self-confidence.

Slowly, the level of support Kate needed was reduced from 24 hours to 16 hours per week as she progressed with achieving the outcomes. Kate was supported to apply for housing. During this period, she had a fall and had to be hospitalised for a hip replacement surgery. She received continuous support from the HASI plus team and was supported to access an independent living unit in a residential aged care facility. She is happy and well settled in her new accommodation.

*Name has been changed for privacy

Once people are able to find appropriate affordable or social housing, people with mental health issues who may be experiencing other co-occurring issues such as alcohol and drug dependence, poverty and economic disadvantage are likely to require support to maintain their tenancies. Tenancy support should include services that are able to provide referrals to community services to address social isolation, increase community connectedness and general wellbeing.

Room to Grow Program

From July 2015 to June 2016, MA implemented and evaluated an intervention for hoarding disorder and domestic squalor across the central and eastern Sydney region. The pilot program aimed to address the physical, cognitive and psychological factors contributing to situations of severe domestic squalor and hoarding disorder, thereby reducing the risk of tenancy loss and homelessness.

Within the program, participants progressed through an individualised case coordination plan with a number of potential referral pathways dependent on diagnosis, co-morbidities, living conditions and insight/motivation. Participants transitioned through a diagnostic or assessment phase, followed by a referral process to relevant services and encouragement to access these, proactive encouragement to engage with case management, access cognitive rehabilitation and/or cognitive behavioural therapy where appropriate, and to move through to final transition into ongoing case management and monitoring to prevent recurrence towards program exit.

Mission Australia's *Room to Grow evaluation report* found an increase in personal wellbeing of participants.[57] The program made a statistically significant positive change in the clutter and cleanliness of participants living environments and overall wellbeing, based on the Environmental Cleanliness and Clutter Scale (ECCS) and Personal Wellbeing Index (PWI) measures. Improvements were also seen in participant's subjective assessment of clutter in their homes, in participant's capacity to complete instrumental activities of daily living and in participants' overall cognitive functioning.

Income support

As discussed under the previous section on suicide prevention, there is a clear link between financial pressure and mental health issues. Thus, it is evident that measures and strategies to address mental

[57] Mission Australia, Room to Grow Program Evaluation Report, 2016, accessible at: https://www.missionaustralia.com.au/publications/research/homelessness

health issues must focus on addressing a range of factors including assisting people who are experiencing financial pressure.

Mission Australia's *Working through it': A Youth Survey report on economically disadvantaged young people* examined the impact of intergenerational disadvantage young people from economically disadvantaged backgrounds. These young people reported a higher level of personal concern about a range of issues that each impact upon mental health.[58] Compared with respondents with parent/s or guardian/s in paid work, higher proportions of economically disadvantaged respondents indicated they were extremely/very concerned about family conflict (24.7% compared with 17.1%), discrimination (16.1% compared with 10.3%), domestic/family violence (14.2% compared 9.2%), bullying/emotional abuse (20.0% compared with 15.4%) and suicide (20.2% compared with 15.4%).[59]

Current social security payments including the Newstart Allowance, Youth Allowance, and Commonwealth Rental Assistance (CRA) are insufficient for many people, particularly those in lone households and in the private rental market.[60] It is widely accepted that these payments are far too low and are acting as an impediment to people looking for work.[61] The National Housing Supply Council calculated that 60% of people who are on low incomes in the rental market are in housing stress[62] and therefore at risk of homelessness. Even for those receiving CRA, 41% of people are still living in rental stress after the payment is taken into account.[63] This financial pressure may result in people experiencing deteriorating mental and physical health, exacerbate existing mental health issues and increase social isolation.

It is estimated that over 33% of the Disability Support Pension (DSP) recipients identify psychological or psychiatric conditions as their primary medical condition.[64] However, it is reported that the accessibility of DSP has been gradually narrowed down over the years and only 27% of applications for DSP were successful leaving people on the lower rate of Newstart with more strenuous mutual obligation.[65] New

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[58] Mission Australia, Working through it': A Youth Survey report on economically disadvantaged young people report, 2019, p. 33, accessible at: https://www.missionaustralia.com.au/publications/youth-survey

[59] Ibid

[60] See further: W. Stone, S. Parkinson, *et al* (2016) *Housing assistance need and provision in Australia: a household-based policy analysis*, AHURI Final Report 262, Melbourne, accessible at: https://www.ahuri.edu.au/__data/assets/pdf_file/0021/7617/AHURI_Final_Report_No262_Housing-assistance-need-and-provision-in-Australia-a-household-based-policy-analysis.pdf

[61] See further: Business Council of Australia, Submission to the Senate Inquiry into the Adequacy of the Allowance Payment System for Jobseekers and Others, accessible at: http://www.bca.com.au/publications/submission-to-the-senate-inquiry-into-the-adequacy-of-the-allowance-payment-system-for-jobseekers-and-others

[62] National Housing Supply Council, *Housing Supply and Affordability Key Indicators*, 2012, NHSC, Canberra.

[63] Australian Institute of Health and Welfare, Housing Assistance in Australia 2017, accessible at: https://www.aihw.gov.au/reports/housing-assistance/housing-assistance-in-australia-2017/contents/financial-assistance

[64] Department of Social Services, Disability Support Pension, June 2016, accessible at: https://data.gov.au/data/dataset/4ccff587-4a46-4ab9-8833-76dadaa10ebe/resource/b6c50479-ffce-4d12-9fe2-afef7b2282c7/download/disability-support-pension-payment-trends-and-profile-report-june-2016.pdf

[65] C. Knaus, Access to disability pension slashed by more than half, data shows, The Guardian, accessible at: https://www.theguardian.com/australia-news/2018/jun/08/access-to-disability-pension-slashed-by-more-than-half-data-shows

data from the Department of Social Services shows there were 199,907 Newstart recipients with 'partial capacity to work' in December, an increase of 50% – or about 65,000 – over the past five years. Over the same period, the number of disability pension recipients fell from 832,024 to 750, 045, and the rate of successful DSP claims also declined markedly from 69% in 2010 to 29.8% in 2017-18.[66] Adequate income support is crucial for people experiencing various challenges and they should be streamed appropriately to ensure they are unnecessarily burdened by unrealistic reporting requirements.

Mission Australia, along with other community sector organisations as well as other stakeholders including local governments, business sector are currently calling on the government to increase the lowest income support payments by $75.00 per week as part of the Raise the Rate campaign.[67]

Social services including psychosocial disability support services

Currently, there are numerous effective psychosocial disability supports in the community. The National Disability Insurance Scheme (NDIS) is expected to support people with disabilities to enjoy an ordinary life. However, some people who are currently receiving mental health related supports are facing significant challenges to having their NDIS applications approved.[68] Further, there are ongoing concerns in relation to some consumers of community mental health programs who may be ineligible to become NDIS participants if they are experiencing episodic and/or moderate mental illnesses.[69]

Evidence demonstrate that people currently accessing Partners in Recovery (PiR) and Personal Helpers and Mentors (PHaMs) services are unwilling to apply for the NDIS even though their case managers believe that those individuals have a strong chance of getting NDIS approval.[70]

Based on initial modelling by the Productivity Commission, it is projected that at full scheme, there will be approximately 64,000 NDIS participants with a primary psychosocial disability who will meet the access criteria for an individual support package.[71] With over 1 million people living with psychosocial disabilities, it is clear that significant investment is needed in the community mental health area to support those who are likely to miss out on NDIS supports.

Also of concern is the adequacy of funding and the lack of consistency of service provision through the Primary Health Networks (PHN) commissioning model. The level of funding for these services in the future is limited considering the need to deliver services covering large geographic areas. We welcome the additional funding announced in the 2019-2020 federal budget to continue support for people receiving mental health services including PHaMs and PiR. Although the funding will cover transitioning

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[66] Ibid

[67] See further: Raise the Rate Campaign, accessible at: https://www.acoss.org.au/raisetherate/

[68] National Disability Insurance Scheme, NDIS ready, accessible at: https://www.ndis.gov.au/ndis-ready.html

[69] See further: Mission Australia, Accessibility and Quality of Mental Health Services in Remote and Rural Australia, 2018, accessible at: https://www.missionaustralia.com.au/publications/submissions-and-reports/disability-and-mental-health

[70] Mission Australia, Accessibility and Quality of Mental Health Services in Remote and Rural Australia, 2018, accessible at: https://www.missionaustralia.com.au/publications/submissions-and-reports/disability-and-mental-health

[71] S. Masters and T. Shelby-James, Assisting people with psychosocial disability to access the NDIS: a guide for Commonwealth-funded community mental health service providers, Flinders University, South Australia, 2017, p.2.

people into the NDIS or other community supports, there is a likelihood that some people who are ineligible or not accessing the NDIS may disconnect from services entirely. Thus, it is imperative that all levels of governments continue to fund community mental health services.

Home and Healthy program NSW

The Home and Healthy Program aims to reduce the prevalence and impacts of homelessness for adults exiting health facilities in Sydney.

The program supports homeless people and those at risk of homelessness who are leaving hospital or health facilities by offering holistic support to achieve sustained housing, increased workforce capacity and improved wellbeing.

Each participant will be supported during their transition from a health facility then ongoing for up to two years, with an allocated case manager, effective housing strategies and access to a holistic team including mental health clinician and lived expertise worker.

The program is funded via an Impact Investment as part of the NSW Homelessness Strategy, with funding from the NSW Department of Families and Community Services and will commence in July 2019.

Facilitating social participation and inclusion

People with mental health issues remain a highly socially excluded cohort despite mounting evidence to demonstrate the need for social participation, building trusting relationships and engaging in community activities to improve long-term mental health outcomes.[72] Diverse social connections enhance the resourcefulness of an individual's network, reduce isolation and support recovery from mental health problems.[73] Approximately 50% of people with a severe mental illness describe problems with loneliness.[74] It is also known that loneliness and social isolation have a significant impact on mental health and physical wellbeing.[75] For example, research has consistently shown that social isolation is a risk factor for disease and premature death. Analysis of loneliness studies has found that that a lack of social connection poses a similar risk of early death to physical indicators such as obesity.[76] For consumers of mental ill health, the effects of loneliness and isolation can be magnified after services close, with these individuals often presenting to Emergency Departments or crisis services.

[72] M. Newlin, M. Webber, D. Morris and S. Howarth, Social participation interventions for adults with mental health problems: A review and narrative synthesis in Social Work Research, Volume 39, Issue 3, 2015, pp. 167-180.
[73] Ibid
[74] E. Perese, et al, Combating Loneliness among Persons with Severe Mental Illness: Social Network Interventions' Characteristics, Effectiveness, and Applicability, Issues in Mental Health Nursing 26(6):591-609 · August 2005
[75] See further: G. Meadows, et al, Mental Health in Australia: Collective Community Practice, 2012.
[76] J. Holt-Lunstand, et al, Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review, 2015.

There are programs specifically designed to support people experiencing issues with mental health and provide a range of supports to maintain housing, address social isolation and increase access to mental health services.

The Housing and Accommodation Support Initiative (HASI) and Enhanced Adult Community Living Supports (EACLS) in NSW provides psychosocial support to people living with severe and persistent mental illness. This includes access to stable housing, clinical mental health services and accommodation support. Supports include daily living skills, including self-care, prompting personal hygiene, cleaning, shopping, cooking and transport; facilitating access to education, vocational training and employment; participation in social, leisure and recreation opportunities; support in building and maintaining family and community connections; and linkage to other related services.

Support from HASI and EACLS results in improvements in the participant's overall quality of life and, most importantly, assists in their recovery from mental illness. However, one of the challenges with HASI and EACLS service is the lack of availability of appropriate step-down accommodation for those people who are ready to transition out of their HASI support model into the community. More safe and affordable accommodation is required to ensure people can continue their journey to recovery from a place of safety and stability.

Impact of mental health issues on diverse groups

Women with mental health issues

It is estimated that 1 in 7 women in Australia experience postnatal depression.[77] Additional support should be provided to parents, including increasing access to childcare to ensure parents are able to access appropriate mental health services.

Research also demonstrates that women receiving treatment for mental ill health are likely to be reluctant to exercise their rights to protect themselves and the children from domestic and family violence for fear that the perpetrator may use mental illness to deny access to children.[78]

According to Mission Australia's *Gender gaps: Findings from the Youth Survey 2018* report young females were twice as likely to report high levels of concern over coping with stress and mental health (56.0% and 38.5% compared to 26.2% and 20.4% of males).[79] A survey conducted by Women with Disability Australia (WWDA) found that the mental health sector is a key primary site that women and girls with disabilities utilise and disclose their experiences of violence, both current and past.[80] Therefore, clear pathways should be in place for mainstream and mental health related services to refer

[77] Health Direct, Postnatal Depression, accessible at: https://www.healthdirect.gov.au/postnatal-depression
[78] Humphreys, Cathy, and Ravi Thiara, (2003), 'Mental Health and Domestic Violence: "I Call It Symptoms of Abuse"' 33 *British Journal of Social Work* 209-226.
[79] Mission Australia, Gender gaps: Findings from the Youth Survey 2018, 2019, accessible at: https://www.missionaustralia.com.au/publications/youth-survey
[80] Dowse, L., Soldatic, K., Didi, A., Frohmader, C. and van Toorn, G. (2013) Stop the Violence: Addressing Violence Against Women and Girls with Disabilities in Australia. Background Paper. Women with Disabilities Australia.

and support people experiencing or suspected of experiencing domestic and family violence through community based support and vice versa.

Aboriginal and Torres Strait Islander people

The Productivity Commission report *Overcoming Indigenous Disadvantage: Key Indicators 2016* showed worsening mental health outcomes for Aboriginal and Torres Strait Islander Australians and much worse suicide and self-harm rates compared to non-Indigenous Australians.[81] Aboriginal and Torres Strait Islander people (two thirds of whom live in rural, regional or remote areas) were almost three times as likely as non-Indigenous people to report high or very high levels of psychological distress.[82] Limited or lack of access to age and culturally appropriate mental health supports in regional and rural areas can increase the risk of suicidal ideation among Aboriginal and Torres Strait Islander young people.[83]

In remote communities there can be particular challenges with service delivery. For example, Mission Australia delivers community mental health services in Papunya in the Northern Territory and the surrounding areas (Hermannsburg, Mt Leibig, Kintore and Haasts Bluff) that are 'communities-in-common'. This means that the residents of these communities are highly transient between these places and do not consistently reside or access services in any one place. Living with and moving across extended -family homes is common and poses a significant challenge to engaging and following up with mental health services. Often when staff visit Papunya they may be unable to locate a participant (who may have moved temporarily to a neighbouring community-in-common) and different service models are required to meet the needs of remote communities.

Strict criterion placed on the services by the funding bodies can limit eligibility for community mental helath services. For instance, individuals who may benefit from the program cannot be included due to their primary residence being one of the communities-in-common. In other words, although these individuals may meet the eligibility criteria, they might not be a registered resident of the area where the program is being delivered. This does not meet the needs or understanding of the community who see residency in these places as interchangeable. Service models should provide sufficient flexibility to address these issues and deliver services to people who would benefit from them.

The current national mental health strategies and frameworks in place provide the foundation for service development and delivery which are co-designed with communities and approved by the

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[81] Productivity Commission**,** *Overcoming Indigenous Disadvantage: Key Indicators 2016,* Chapter 8.37-8.47.

[82] National Rural Health Alliance, *Factsheet: Mental Health in Rural and Remote Australia*, December 2017, accessible at: http://ruralhealth.org.au/sites/default/files/publications/nrha-mental-health-factsheet-dec-2017.pdf

[83] P. Dudgeon, R. Walker, *et al*, *Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander People*: Issues paper no. 12, produced for the Closing the Gap Clearinghouse, 2014, accessible at http://www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Our_publications/2014/ctgc_ip12.pdf

respective community leaders.[84] Mission Australia strongly encourages the implementation of these frameworks through Aboriginal Community Controlled Organisations.

Developing the Aboriginal health workforce and peer workforce as well as involving communities in service design and delivery have been identified as important first steps in more culturally sensitive practices.[85] A well trained, well supported and well-resourced Aboriginal mental health workforce is widely seen to be critical to the delivery of equitable, culturally engaged mental health care for Aboriginal and Torres Strait Islander people.[86]

Institute for Urban Indigenous Health (IUIH) training programs[87]

School Based Traineeships School-based trainees work across a range of settings and train as allied health assistants. Trainees complete one or two days a week of work experience and rotate each term through the Deadly Choices health promotion team, the Work it Out chronic disease rehabilitation program and children's therapy services. Trainees receive a comprehensive introduction to work as an allied health assistant, and are mentored by allied health and health promotion staff. IUIH is committed to mentoring trainees through their traineeship and into work and/or further study after training. Over half of the 2013 trainee graduates are currently enrolled in the University of Queensland Tertiary preparation program. IUIH is partnering with University of Queensland to launch Deadly Pathways. This program provides intensive support for Indigenous children from disadvantaged families to access practical pathways into secondary and tertiary education.

Services designed to benefit Aboriginal and Torres Strait Islander people should be co-designed and implemented with community members, Elders and Aboriginal Community Controlled Organisations to ensure they are culturally secure, adapted and effective. Particularly in regional and remote areas, relationships with the local community and having a strong understanding of local cultures and protocols are critical to developing the necessary trust from community members to engage with local services. Further, the location and confidentiality of services are key to uptake of support in small communities.

[84] Commonwealth of Australia 2017. National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing. Canberra: Department of the Prime Minister and Cabinet.

[85] See further: Hansard, Report on Proceedings before Portfolio Committee No. 2 – Health and Community Services, accessible at: https://www.parliament.nsw.gov.au/committees/DBAssets/InquiryEventTranscript/Transcript/10127/Hearing%20Transcript.pdf

[86] Northern Territory Mental Health Coalition, Mental Health & Suicide Prevention Service Review, 2017, accessible at: http://apo.org.au/system/files/126901/apo-nid126901-558076.pdf

[87] Institute for Urban Indigenous Health. 2014. "Research, Innovation & Workforce Development." At http://www.iuih.org.au/Services/Research_Innovation_Workforce_ Development#schoolbasedtraineeships, accessed September 18, 2018

People from culturally and linguistically diverse (CALD) backgrounds

Refugees and people seeking asylum are particularly vulnerable to self-harm and suicidal behaviour.[88] For people seeking asylum who spent time in immigration detention, the experience of detention also increases the likelihood of mental health problems such as anxiety, depression, and Post Traumatic Stress Disorder (PTSD), as well as self-harm behaviours and suicidal ideation.[89]

Language and cultural barriers are also highly relevant for mental health. Non-English speaking migrants are reported to be less likely to communicate that they have a mental health disorder compared to Australian born residents.[90] Pre and post migration experiences, limited communication skills and unfamiliarity with Australian support services may further isolate people from CALD backgrounds. The relationships with immediate and extended family may also play a critical role in young people's lives. Culturally sensitive and appropriate supports at the initial stages of settlement are essential for these people, particularly those who have had traumatic experiences prior to migration.

Risk factors of suicidal behaviour among immigrants are influenced by a range of factors including living circumstances in the host country, experiences in the country of origin and low socio-economic status.[91] Considering the increase in the number of refugees from Iraq and Syria, a number of positive measures have been adopted by NSW government to support newly arrived young refugees including mental health supports.

Happy Healthy Minds Program

Mission Australia's Happy Healthy Minds Program (also known as Liverpool Family Mental Health Support Program) provides a range of flexible, responsive, non-clinical mental health support services to meet the needs of young people aged 8– 18 years, affected by, or at risk of mental illness. The service offers holistic case management, information and referrals to other services, practical and home based support, education and community development as well as programs and group work activities.

As part of the humanitarian entrant component of the project, young people from refugee backgrounds have been provided with opportunities to participate in a range of activities including a fishing trip to the coast with the support of Liverpool PCYC, Green Valley Police and peer-support workers who shared similar refugee backgrounds.

[88] AFRAM (Australian Medical Students' Association (AMSA) campaign on Refugee and Asylum Seeker Mental Health), *The Effect of Australia's Policy on Refugee Mental Health,* accessible at: http://afram.amsa.org.au/the-effect-of-australias-policy-on-refugee-mental-health/

[89] K. Ratkowska and D. De Leo, Suicide in Immigrants: An Overview in Open Journal of Medical Psychology, 2013, 2, 124-133.

[90] Migration Council of Australia, The Health Outcomes of Migrants: A Literature Review, 2015, accessible at: https://migrationcouncil.org.au/wp-content/uploads/2016/06/2015_Smith.pdf

[91] ibid

Successful programs such as these should be continued to ensure people from refugee backgrounds at risk of mental illness are provided early intervention supports to engage in their new local community.

Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people

Although the discussion paper aims to gather feedback in relation to population subgroups more at risk of mental ill-health due to inadequate participation and requisite access to services, and several references to diverse groups such as Aboriginal and Torres Strait Islander communities, people from migrant and refugee backgrounds, carers and the like, it is concerning that mental health related needs of people from LGBTI backgrounds are relatively invisible in the discussion paper.

People who identify as LGBTI were found to be six times more likely to attempt to end their life compared to their peers.[92] Discrimination, prejudice, isolation and family rejection because of their sexuality and gender identity may increase the risk of suicide and suicidal ideation. Rejection by family based on one's core identity (sexual orientation or gender identity) was more damaging than other family conflicts and may have a greater impact on mental health.[93]

Within the LGBTI community, young transgender people had a higher tendency to attempt suicide compared to other LGBI young people.[94] A report released in September 2017 found that almost 50% of transgender young people in Australia have attempted suicide at some point in their life and over 80% had suicidal thoughts.[95] The report sets out a series of recommendations including enacting transgender inclusive legislation and policies, transgender community-led funding and peer-based, proficient, holistic service provision and the like.[96]

In addition to the above, the National LGBTI Mental Health and Suicide Prevention Strategy identify the following broad measures:[97]

- Recognition and specific inclusion of LGBTI populations in the development of any child, youth or family strategies, frameworks, programmes and services.
- Timely access to appropriate multi-disciplinary clinical and non-clinical mental health services that have expertise that is appropriate for LGBTI children and young people, and their families.

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[92] National LGBTI Health Alliance, LGBTI people, Mental Health and Suicide, 2011, p.3 accessible at: http://lgbtihealth.org.au/sites/default/files/Biefing_Paper_FINAL_19_Aug_2-11.pdf

[93] R McNair, et al, GALFA LGBTQ Homelessness Research Project, 2017, p.32.

[94] Ibid

[95] P. Strauss, A. Cook, et al, *Trans Pathways: the mental health experiences and care pathways of trans young people*, Telethon Kids Institute, p.10.

[96] Ibid

[97] Commonwealth Department of Health, *National LGBTI Mental Health and Suicide Prevention Strategy*, 2016, p. 25, accessible at: http://lgbtihealth.org.au/wp-content/uploads/2016/12/LGBTI_Report_MentalHealthandSuicidePrevention_Final_Low-Res-WEB.pdf

- Support and resourcing for the establishment, development and growth of LGBTI peer led programmes, services organisations and support groups for LGBTI children and young people.
- Develop and resource mental health and suicide prevention initiatives that specifically target LGBTI children and young people and where possible are implemented and delivered by LGBTI peer led organisations that have a core mission of providing programmes and services to LGBTI children and young people.

Mission Australia encourages the adoption of such policies to prevent the high rates of suicide, suicidal ideation and mental health issues among LGBTI people as a matter of priority.

Ageing population

The prevalence of psychosocial disability generally increases with age, to 1 in every 4 women (27%) and 1 in every 5 men (21%) aged 85 years and over.[98] Nearly three-quarters of Commonwealth Government expenditure on ageing and aged care services is currently dedicated to residential aged care.[99] Some older people who are homeless or at risk of homelessness, as well as those in the rental market who are unable to upgrade their rental properties to meet their accessibility needs, are likely to prematurely move to residential aged care facilities. Mental health supports in the home are likely to be much more effective for the older people themselves and cost effective for the government. The ability to provide secure, long-term and sustainable housing coupled with in home services including mental health supports reduce the cost of hospital and emergency department admissions and will save a significant amount of funding for the government and the mental health system in general.

Homelessness, particularly the disadvantages associated with it, can contribute to premature ageing through earlier onset of health problems more commonly associated with later life.[100] Research also demonstrates that homelessness and housing stress has a significant bearing on mental health of older people.[101]

Where provision of support to maintain housing is not appropriate or possible for older people with psychosocial disability, specialist residential aged care is vital for people who are experiencing or at risk of homelessness. These services are equipped to provide the requisite professional mental health and other supports.

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[98] Australian Bureau of Statistics, (2017), Psychosocial Disability, 4430.0 - Disability, Ageing and Carers, Australia: Summary of Findings, 2015, accessible at: https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4430.0Main%20Features902015?opendocument&tabname=Summary&prodno=4430.0&issue=2015&num=&view=

[99] Australian Institute of Health and Welfare, Residential aged care and Home Care 2015–16, accessible at: https://www.aihw.gov.au/reports-data/health-welfare-services/aged-care/overview

[100] Australian Institute of Health and Welfare, Older Australia at a glance, 2018, accessible at: https://www.aihw.gov.au/reports/web/194/older-australia-at-a-glance/contents/diversity/people-at-risk-of-homelessness

[101] A. Morris, The Australian Dream, Housing Experiences of Older Australians, 2016, p. 147-149.

Justice System

Physical and mental health problems can further disadvantage people in the criminal justice system. Children and young people with disability, particularly those with mental illness and/or intellectual disability are significantly over-represented in the juvenile justice system.[102] A report produced by the Australian Human Rights Commission identified that people with disabilities do not enjoy equality before the law when they come into contact with the criminal justice system in Australia.[103]

Substance use related issues, particularly those that are comorbid with mental health disorders, can increase the risk of crime, and especially violent crimes.[104]A considerable proportion of people engaged in the juvenile justice system, or supported by diversionary programs, have a history of drug and alcohol dependence.[105] There should be a greater emphasis on diversion of people experiencing mental illness from contact with the justice system and particularly from detention.

Upon the release from detention or other justice related settings, people with physical or mental health issues should have access to a range of supports to find appropriate accommodation, access to health and mental health related services, supports to continue education or employment and other multi-disciplinary wrap around supports.

There are numerous services that are providing effective services to people who are engaged or likely to engage with the criminal justice system. Innovative and pragmatic programs such as these should be replicated across the country and tailored to local community needs.

[102] R. McCausland, S. Johnson, E. Baldry and A Cohen, *People with mental health disorders and cognitive impairment in the criminal justice system Cost-benefit analysis of early support and diversion*, UNSW and PWC, p.3 accessible at:
https://www.humanrights.gov.au/sites/default/files/document/publication/Cost%20benefit%20analysis.pdf
[103] Australian Human Rights Commission, *Equal before the Law: Towards Disability Justice Strategies,* 2014, p. 8
[104] G. Ritchie, S. Weldon, L. Freeman, G. MacPherson, K. & Davies, *Outcomes of a drug and alcohol relapse prevention programme in a population of mentally disordered offenders*, The British Journal of Forensic Practice, 13 (1), 2011, pp.32 – 43.
[105] See further: J. Wundersitz, *Criminal justice responses to drug and drug-related offending: are they working?* Australian Institute of Criminology, Technical and Background Paper No. 25, 2007.

Synergy Auto Repairs - Victoria

Mission Australia's Synergy Auto Repairs is a social enterprise based in North Melbourne that offers customers a full suite of smash repair services, while providing a flexible accredited training program and support for young people aged 16-20 with a history of motor vehicle related offences. The program harnesses participants' interest in cars and aims to help them build a career in a field that matches their interests. The young people experience a range of challenges including mental illness, alcohol and drug issues, housing and homelessness and, issues with literacy and numeracy.

This social enterprise equips participants with the skills to commence a smash repairs apprenticeship. The initiative is an Australian-first partnership between Mission Australia, the National Motor Vehicle Theft Reduction Council (NMVTRC), Kangan TAFE, and Suncorp Group.

An evaluation of the program found a high degree of self-reported mental health problems in this cohort of young people as well as housing issues, which needed to be addressed.[106] This service model has the ability to link or refer participants to a diverse range of community supports, including mental health services.

Justice system and alcohol and drug related offences

Alcohol and other drug dependence may result in people getting engaged in the justice system. Considering the intersectionality between alcohol and drugs, mental health issues and involvement in the justice system, it is imperative that there are adequate community based diversionary programs. Currently, there is a shortage of diversionary service supports for young people despite the increasing need to provide diversionary supports to break the criminogenic cycles.

Substance use related issues, particularly those that are comorbid with mental health conditions, can increase the risk of crime, and especially violent crimes.[107] A considerable proportion of people engaged in the juvenile justice system, or supported by diversionary programs, have a history of drug and alcohol dependencies and often a history of mental health issues.[108] Diversionary and rehabilitative services need to be age appropriate, culturally sensitive and meet the individual's needs.

[106] M. Thielking, J. Pfeifer, et al, Synergy Automotive Repairs Program: Process Evaluation Report, Melbourne, 2016, accessible at: https://www.missionaustralia.com.au/publications/research/young-people/502-synergy-automotive-repairs-program-process-evaluation-report-1/file

[107] G. Ritchie, S. Weldon, L. Freeman, G. MacPherson, K. & Davies, *Outcomes of a drug and alcohol relapse prevention programme in a population of mentally disordered offenders*, The British Journal of Forensic Practice, 13 (1), 2011, pp.32 – 43.

[108] See further: J. Wundersitz, *Criminal justice responses to drug and drug-related offending: are they working?,* Australian Institute of Criminology, Technical and Background Paper No. 25, 2007.

Junaa Buwa! Centre for Youth Wellbeing and Mac River

Junaa Buwa! and Mac River are residential rehabilitation centres for young people who have entered, or are at risk of entering, the juvenile justice system and have a history of alcohol and other drug use. Funded by the NSW Department of Justice, these services offer residential and outreach services as well as educational and living skills training and aftercare support. The services cater for young people aged 13-18 years in NSW with Junaa Buwa! located in Coffs Harbour and Mac River in Dubbo. Young people undertake residential rehabilitation for 12 weeks which is followed by 12 weeks after care support. The services take a holistic approach including case management addressing mental, physical, social and inter and intra personal challenges. At Junaa Buwa! more than 80% of clients are Aboriginal and Torres Strait Islander young people with a similar profile at Mac River. The Junaa Buwa! Alcohol and Other Drug Outreach Program was established in 2012 and targets 13 to 18 year olds at more than eight local high schools.

Mental health and incarcerated population

Studies have found that the prevalence of psychiatric disorders were significantly higher for people in prison than that found in the Australian community. For example, research in NSW identified that 74% of the prison population had at least one psychiatric disorder.[109] This is significantly higher compared to the general population (over 20%).[110]

Internationally and nationally, strategies have been adopted to address the disproportionately high number of offenders with a mental illness, including, diverting mentally ill offenders out of the criminal justice system who have been charged with relatively minor offences, admission of inmates requiring involuntary psychiatric treatment, admission of those found 'not guilty by reason of mental illness' and admission of those found 'unfit to stand trial' to secure forensic mental health facilities, and follow-up in the community of 'high risk' and forensic psychiatric patients.[111]

The Commonwealth Parliamentary Inquiry report *Indefinite detention of people with cognitive and psychiatric impairment in Australia* makes a series of recommendations including implementation of a Disability Justice Plan, specific measures in relation to people held under forensic orders and, a range of options for the placement of forensic patients beyond unconditional release and prison.[112] Mission Australia supports the implementation of these recommendations.

[109] T. Butler, S. Allnutt, Mental Illness Among New South Wales' Prisoners. NSW Corrections Health Service, 2003
[110] Australian Institute of Health and Wellbeing, Mental Health Services in Australia, 2019, accessible at: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary/prevalence-and-policies
[111] P. Mullen et al, Forensic mental health services in Australia, International Journal of Law & Psychiatry 2000;23(5-6): pp. 433.
[112] The Senate Community Affairs Reference Committee, *Indefinite detention of people with cognitive and psychiatric impairment in Australia*, November 2016, p. 173

Investment into more specialist community based supports for people with mental illness who have been in contact with the Justice system is also required including a focus on housing, drug and alcohol support and employment.

Skills acquisition and employment

Education and training

The relationship between mental ill-health and other issues such as homelessness and alcohol and drug dependence is bi-directional in that it can be a cause or an outcome which can disrupt or impact on education and training.

Experiences of young people

Mission Australia conducts an annual youth survey with the participation of young people aged 15-19 years. Last year, over 28,000 young people participated in the survey and 43% of the young people identified mental health as one of the top concerns in Australia today. Further, the number of young people identifying mental health as a concern has nearly doubled since 2016. [113]

Concerningly, the top 3 issues of personal concern for young people in 2018 were coping with stress (43%), school or study problems (34%) and mental health (31%). All these directly relate to poor mental health. Unaddressed self-identified concerns in relation to elevated levels of stress may lead to the development of other serious mental health issues such as anxiety or depression. In addition, 30% of young people identified body image issues as a personal concern and there can be early indications of eating disorders for some people.

The participants of Mission Australia's youth survey indicate that they are much more likely to seek support from friends (85%), parents (76%) and relative/family friend (60%).[114] Interestingly, about 50% of young people indicated internet as a source of help and a lesser number of young people identified teachers and school counsellors (38% and 36% respectively) as sources of help. These demonstrate the diverse range of sources of supports young people access.

Mission Australia has written extensively on the need for targeted mental health supports for young people based on the findings of the youth survey results.[115] We also recommend that investment is targeted to co-designed programs with young people from diverse backgrounds who are likely to access these services.

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[113] Mission Australia, Youth Survey Report, 2018, accessible at: https://www.missionaustralia.com.au/publications/youth-survey/823-mission-australia-youth-survey-report-2018/file

[114] Ibid p. 26

[115] Mission Australia and Black Dog Institute, Youth mental health report Youth Survey 2012-16, 2017, accessible at: https://www.missionaustralia.com.au/publications/research/young-people/706-five-year-mental-health-youth-report/file and Youth mental health and homelessness report, 2017, accessible at: https://www.missionaustralia.com.au/publications/research/young-people/720-mission-australia-youth-mental-health-and-homelessness-report/file

Following continuous advocacy by the community sector, there are some state government initiatives that identified the needs of young people and aim to provide appropriate supports such as the NSW and Federal government investment to increase the number of full-time onsite school counsellors or psychologists and full-time onsite student support officers.[116] It is encouraging to see government investment into providing additional mental health services in schools for young people. However, there might be students who prefer to receive support outside the school premises due to stigma and shame. Thus, additional supports need to be targeted towards young people who are at risk of disengaging from school as well those who are currently disengaged from school.

Navigator (VIC)

Navigator is a Victorian Government initiative that provides support for disengaged young people, aged 12- 17 years, to re-engage with an education or training pathway. Navigator services seek out disengaged learners and actively work with them and their support networks, providing the support required for a successful return to education.

Flexible Learning Options (SA)

Flexible Learning Options (FLO) is a successful program in South Australia that provides casework support and individualised learning programs for high school students aged 13-19, young parents and young people with disabilities up to 25 years who have disengaged from mainstream schooling. The learning that FLO students access can be on-site or external to their schools such as in dedicated co-located or off-site flexible learning centres (FLCs), at VET courses or apprenticeships. In addition, their attendance is supported by active case management that helps students to work out personal learning plans, addresses barriers to learning and re-engagement, supports them to access the services they need and links them to employment opportunities or social activities.

Case managers advocate on behalf of students and their role is critical to motivating FLO students to achieve attainable learning and employment goals. Mission Australia has been providing FLO in SA since 2007 and currently supports over 500 students through 32 different schools and locations.

An independent evaluation of the Mission Australia's FLO program demonstrated that it has had a significant and positive impact on the lives of students.[117] In many instances FLO attendance was described by students as being personally transformative, potentially life-saving, and a significant driver of re-engagement and social inclusion. The evaluation showed that, as a result of attending the

[116] NSW Government, Media release: Huge boost to support student welfare and mental health, 2019, accessible at: https://www.nsw.gov.au/your-government/the-premier/media-releases-from-the-premier/huge-boost-to-support-student-welfare-and-mental-health/

[117] University of Adelaide and Mission Australia, What does Success Look Like? An Evaluation of Mission Australia's Flexible Learning Options (FLO) Program (South Australia), 2018, accessible at: https://www.missionaustralia.com.au/publications/research/young-people/765-what-does-success-look-like-an-evaluation-of-mission-australia-s-flexible-learning-options-flo-program-south-australia/file

program and receiving casework support, the majority of FLO students are able to identify educational or job-related goals, as well as discover their ambitions and put strategies in place to achieve them.

Government support to find and maintain a job

Employment can provide people with mental illness an opportunity to increase social and economic participation.[118] Numerous programs and services are available to ensure people with disabilities receive the requisite supports to access and maintain employment such as Disability Employment Services (DES). Additional supports for people with mental health issues are also available under jobactive. However, there is little or no communication between the two employment support systems, despite jobactive having an active case load of over 181,000 people with disabilities by 30th June 2018.[119] The majority of these people with disabilities are likely to be in Stream C of jobactive supports. However, there are no targeted supports that are tailored to the needs of people with disabilities within jobactive.

Personal Helpers and Mentors (PHaMs) Employment Services

PHaMs Employment Services provide support for people with a mental illness receiving the Disability Support Pension or other government income support payments who are engaged, or willing to engage, with employment services and who have economic participation as a primary goal in their Individual Recovery Plan.

Organisations are funded to provide specialist support and work with government employment services, such as Disability Employment Services, jobactive, state-funded services and social enterprises, to assist PHaMs participants to address non-vocational issues that are barriers to finding and maintaining employment, training or education. PHaMS Employment supports people with significant mental illness to minimise non-vocational barriers through outreach case management.

Case study

Ann* made a self-referral to the PHaMS Employment service in Victoria. She was 24 years old and was from a culturally and linguistically background. By the time she contacted PHaMs employment she

[118] See further, Australian Human Rights Commission, Willing to Work: National Inquiry into Employment Discrimination Against Older Australians and Australians with Disability, 2016, accessible at: https://www.humanrights.gov.au/our-work/disability-rights/publications/willing-work-national-inquiry-employment-discrimination

[119] Department of Jobs and Small Businesses, Labour Market Information Portal, jobactive and Transition to Work (TtW) Provider Caseload by Selected Cohorts, accessible at: http://lmip.gov.au/default.aspx?LMIP/Downloads/EmploymentRegion

had lived in Australia for 10 years. She has been linked to an employment services provider for 2 years but she was unable to achieve any positive outcomes or build a relationship with the service provider.

Following a meeting with Mission Australia, a case conference was initiated and it was identified that Ann could not work fulltime due to her physical and psychosocial barriers including having Post Traumatic Stress Disorder (PTSD) high levels of anxiety around participating in the community.

Following the case conferencing process, Ann was supported to secure a volunteer role at a well-known charitable organisation. It later became evident that transport was an issue for Ann. The PHaMs Case Manager worked with her employment provider to find her an alternative work experience closer to home. By supporting Ann with her goal of participating in the workforce, she was able to secure paid employment.

*Name has been changed for privacy

However, with the rollout of the NDIS, PHaMs is currently being phased out, leaving many people who are ineligible for the NDIS without the necessary community mental health supports or appropriately tailored employment supports. Considering the success of the PHaMs Employment program and the outcomes achieved to support people with mental health issues to obtain employment, we recommend investing in similar models for targeted groups such as people with psychosocial disability with collaboration and coordination with other Commonwealth, state and territory government departments.

DES program is better suited to support people with disabilities, however, the stringent reporting requirements, the outcome measurements, KPIs for service providers and other supports and wage subsidies are often still too restrictive. In the event where DES supported employees need to take time off, especially those with episodic mental health issues, there are inadequate supports available. For example, when an employee is unable to work for a brief period due to the episodic illness, the subsidies and the supports cease to apply. There needs to be more flexibility in the program to allow for longer periods of breaks in employment and additional support for the employers to hold the position open until the employee is ready to return to work.

Other strategies to improve employment outcomes for people accessing DES could include reducing benchmarking hours, increasing targeted strategies and incentives to ensure employers are able to create flexible work places, national strategies promoting employment opportunities to those with mental illnesses and increasing support for them to remain employed.

To date the uptake of employment supports in NDIS Plans has been low.[120] Across relevant age groups (15-64) only about 1 in 5 participants are receiving employment supports in their plans, making up a

[120] Faye Lawrence, Increasing Employment Supports in NDIS Plans – Where to from Here?, 2018, accessible at: http://www.disabilityservicesconsulting.com.au/resources/increasing-employment-supports-ndis-plans

mere 2.5% of annualised committed support.[121] The future employment services should ensure that the employment service providers are able to link with complementary supports that people receive including the NDIS to achieve meaningful long-term employment outcomes for people with disabilities.

Furthermore, the challenges of entering the employment market is often outside the control of the people expecting to find employment. A research report of the Australian Government shows that while the majority of Australian employers are open to hiring people with disabilities (77%), a much lower proportion (35%) demonstrate behavioural commitment to doing so.[122] In addition to the lack of commitment to employ people with disabilities, limited availability of employment opportunities also impact on the individual's ability to enter job markets. There is ample evidence to demonstrate that most people with disabilities including those with mental health issues are placed in low paid jobs that do not reflect the individual's qualifications or career aspirations.[123]

Considering the importance of economic participation for self-esteem, independence and social isolation, there should be appropriate services to support people gain meaningful, long-term employment. However, people with mental illness looking for work should not be placed under pressure with unnecessary and inflexible reporting requirements.

Peer support mental health workforce

A peer support approach is able to produce positive outcomes for people experiencing mental illness as people who have similar experiences can better relate and can consequently offer more authentic empathy and validation.[124] In addition to the benefits for people using services, mental health and financial benefits of peer support and peer work are also demonstrated for peer workers themselves.[125] Training and work as a peer worker can increase an individual's skill base, which makes them more employable and opens up other employment and educational opportunities.[126]

Understanding the importance of lived experience in delivering services in local communities, Mission Australia has developed and implemented a suite of resources and training modules for Lived Expertise staff, their managers and co-workers. Mission Australia's Lived Expertise practitioners bring significant value to the organisation through their contribution to the development of person led and recovery focused support and care.

Mission Australia currently has Lived Expertise staff employed in each state and territory (with the exception of ACT). Lived Expertise practitioners enrich the provision of mental health services (and other

[121] Ibid
[122] Jane Prentice, Assistant Minister for Social Services and Disability Services, Media release: Businesses are missing out, 27 July 2018, accessible at: https://ministers.dss.gov.au/media-releases/3471
[123] See further: M. Walsh, P. Stephens and S. Moore, Social Policy and Welfare,
[124] J. Repper and T. Carter, A review of the literature on peer support in mental health services in Journal of Mental Health, August 2011; 20(4): 392–411.
[125] See: Health Workforce Australia, Mental Health Peer Workforce Study, 2014, pp. 11-12.
[126] Health Workforce Australia, Mental Health Peer Workforce Literature Scan, 2014, p. 10.

services) by bringing skills and knowledge gained through lived experience and engagement with support services, to collaborate with others in overcoming life adversity.

Connections Program Broken Hill NSW

Mission Australia, in partnership with Far West Local Health District, have partnered for the previous 2 years to deliver a social inclusion program, Connections, to address loneliness, after hours, in the Far West of the state. The program is delivered after hours to support connection in mainstream community activities for those who are lonely or socially isolated.

Connections aimed to reduce social isolation by supporting people to develop a network within their community; provide an informal, non-clinical after-hours support service for socially isolated people when no other services are open, reduce reliance on after hours' crisis support; provide additional employment opportunities in a remote area and develop a peer workforce in a remote area

Since its inception, over 100 unique individuals have accessed Connections and, while there is some variation from month to month, attendance is trending up. Attendance has increased confidence, hope, connection, friendships and a sense of belonging to their own community for participants.

Emergency Department presentations, and Inpatient acute days have dramatically presentations have reduced for 5 most frequent attendees, at a cost saving of over $710,000.

8 Peer Support Workers (PSWs) have been employed since Connections opened, one has used the skills gained to move to other employment in Mission Australia.

This demonstrates the positive outcomes delivered in rural NSW in a short span of time to build trust, rapport and community connections. Creating a peer support worker network has created employment opportunities for people in the community who understand the cultural nuances and needs of local communities as well as the existing services and other relevant support networks. Therefore, Mission Australia recommends that programs such as Connections and employ peer workers with lived experience should continue to be funded. This is particularly important to address the workforce issues in rural and remote areas.

Peer Support Worker program in Orange NSW

In partnership with Western Local Health District, Mission Australia have co-designed and implemented an inpatient peer support team in the largest psychiatric hospital – Bloomfield campus. This program was funded from a short term revenue stream, and is designed to provide peer support services to people in inpatient wards.

This project included the recruitment of 7 peer support workers to be based full time with the hospital's multi-disciplinary team across a range of specialist wards including Forensic Mental Health, Child and Adolescent Mental Health, Adult Acute Unit, State-wide Rehabilitation, Older Persons Mental Health Unit and Involuntary Alcohol and Drug Treatment Unit.

An additional peer worker is based in the Emergency Department, particularly to engage and work with people who are experiencing suicide ideation or have attempted suicide both during and after hours. The Peer workers provide emotional support and comfort to the hospital patients, families and carers, particularly being able to draw on their own lived experience of the hospital system. Further, a range of peer workers have been involved in systems-level activities and service development activities on their respective wards.

About 30 – 35% of the patients at the hospital are Aboriginal and Torres Strait Islander people and currently the program has recruited 3 peer workers who identify as Aboriginal and Torres Strait Islander and therefore, are able to deliver culturally appropriate and sensitive services, particularly for those that have been required to travel away from country for treatment.

Anecdotal evidence demonstrates that the services these peer workers provide are immensely valued by the hospital staff, the patients and their families.

All peer workers are provided with access to ongoing training including paid access to Certificate IV level education. Therefore, in addition to supporting hospital patients, this service provides an opportunity for people with mental health and other significant issues to engage in paid employment in an area where they are able to use their life experiences and learning to support others, build on their skills and confidence and plan their future career.

This project highlights innovative solutions to enhance the patient experience of hospital, through the participation of people with a lived experience into mainstream employment. This program is currently in its pilot phase and is being evaluated; however, it is uncertain if future funding will be extended, as the initial project is time-limited.

Framework to enhance mental health, improve participation and workforce contribution

As discussed above, employment is an important aspect of a person's financial independence and increase their general health and wellbeing. However, there are numerous other factors such as

housing, domestic and family violence or other similar challenges that need to be prioritised before people with mental health issues are likely to be ready to engage with employment.

Coordinated care and a fully integrated system

Community services work with a diverse range of complementary services. Some of these services have formal agreements or arrangements for cross referral or collaboration. The services are currently designed with limited flexibility and strict Key Performance Indicators (KPIs) that result in services experiencing challenges with delivering services that meet the needs of the individuals or the community.

Psychosocial Support Services Northern Sydney - NSW

PSS aims to provide recovery-oriented psychosocial supports tailored to individual needs. The aim is to support people to maintain engagement with community based mental health treatment, improve physical health and wellbeing, develop social skills and meaningful participation in everyday social situations and daily living, minimise alcohol and substance dependence related harm, maintain housing tenancies, increase participation in employment, educational and vocational connections, learn and maintain skills to enhance mental wellbeing, resilience and independence and improve connection with family and community.

The service provides outreach support, available afterhours where necessary. Recovery workers coordinate the delivery of services, supported by a Lived Expertise Worker and Program Manager to lead the service. The service works collaboratively with existing clinical treatment providers including General Practice, allied health service providers, Northern Sydney Local Health District and other community-based services.

This service is funded by Sydney North Primary Health Network.

Funding arrangements

One of the major challenges identified by services is the uncertainty of funding for programs. Often the funding contracts are short-term and do not recognise the challenges specific to rural and remote areas. Finding skilled and appropriately qualified staff to deliver services after funding is approved can take months in certain areas.

> "By the time we find people to deliver the service, we are well into 3 or 4 months of the funding round … There's a lot of pressure to get people on board, get them up to speed and start delivering services. They have to go into the community and build relationships which can also take quite a decent amount of time. When all this is resolved, the 12-month funding period is up and the people we hired have to find new jobs."
>
> Mission Australia, Area Manager NSW

Given the importance of these services in local communities, the commission should conduct a review of current funding levels for services and continuity of funding to ensure services can maintain adequate staffing levels and retain the qualified workforce.

As recommended previously by the Productivity Commission, to allow adequate time for service providers to establish their operations, and have a period of continuity in service provision and handover before the conclusion of the contract (when a new provider is selected), default contract lengths for family and community services should be increased to seven years, and for Aboriginal and Torres Strait Islander specific services, this should be increased to 10 years.[127]

Compared to the service delivery staff in metropolitan or regional areas, the staff and services in rural and remote areas experience additional challenges in meeting the funding contract requirements and key performance indicators (KPIs) identified by the funding bodies. It is important for the government funding bodies to identify these challenges and ensure the KPIs and other requirements are flexible to accommodate the needs and challenges of service delivery in rural and remote areas.

Conclusion

The ability to access early intervention supports and address mental health concerns at the earliest possible time is likely to ensure that people are able to better manage their mental health and associated mental health issues. The programs that are producing positive outcomes, should be funded over the long term and replicated across the country to ensure equitable access to mental health services.

The formal adoption of a social determinants of health framework in policy will be able to address the intersecting issues (such as housing, gender, justice, education/employment) that impact people's mental health and wellbeing. This will support a more cohesive and joined system for people to engage with. Further, a social determinants of health approach will support economic savings within the system, and further support people with mental ill health to fully and actively participate in their communities, and society more broadly.

More investment is required to increase the peer workforce or lived experience experts. This will ensure that the services are equipped to provide more effective services as well as opportunities for people to participate in employment, which in turn increases their financial independence and wellbeing.

[127] Productivity Commission, Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services, No 85, Productivity Commission Inquiry Report, 2017, accessible at: https://www.pc.gov.au/inquiries/completed/humanservices/reforms/report