

Mind Australia Limited

Submission to the Productivity Commission

*Inquiry into the Social and
Economic benefits of Improving
Mental Health*

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1. Introduction

Mind Australia Limited

Mind Australia Limited (Mind) is one of the country's leading community-managed specialised mental health service providers. We have been supporting people dealing with the day-to-day impacts of mental illness, as well as their families, friends and carers for over 40 years. We provide recovery-focused, person-centred support including residential rehabilitation, personalised support, youth services, and family and carer services, and care coordination. We deliver services in our own centres, and outreach programs and residential services in partnerships with clinical agencies around Australia. In the last financial year, Mind provided over 400,000 hours of support service to over 9,000 people, including residential rehabilitation, personalised support, youth services, family and carer services and care coordination.

We also work with people to address poverty, housing, education and employment. It is an approach to mental health and wellbeing that looks at the whole person in the context of their daily life, and focuses on the social determinants of mental health, as they play out in people's lives. We value lived experience and many of our staff have been through their own recovery journey and faced similar challenges.

Mind significantly invests in research about mental health recovery and psychosocial disability and shares this knowledge, developing evidence informed new service models, evaluating outcomes, and providing training for peer workers and other mental health professionals. We also advocate for, and campaign on basic human rights for everyone; constantly challenging the stigma and discrimination experienced by people with mental health issues. Our current research and advocacy priorities are unpaid carers and housing.

Mind presents the following submission to the Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health. We believe this inquiry is a major opportunity to re-evaluate Australia's mental health policy and service system beyond the historical framing of illness and medical interventions. Failure to give more fundamental consideration to the broader socio economic issues underpinning mental health is one of the reasons why past reform efforts have met with limited success, despite the considerable policy attention given to the area. This includes, by one count, 32 separate statutory inquiries into mental health between 2006 and 2012 alone,¹ not including the lengthy 2014 National Mental Health Commission (NMHC) review, and the Productivity Commission's own review into the National Disability Insurance Scheme (NDIS).

The following submission will address those areas of the Issues Paper where Mind feels it can contribute evidence based policy commentary and practical solutions, several of which we believe are capable of being rapidly scaled up. In particular, our submission focuses on the reforms that are needed to enhance productivity and participation for people with high-

¹ Sebastian Rosenberg, 'Latest mental health productivity data reveals scale of reform ahead,' *Sydney Morning Herald*, February 9, 2019.

medium, high and complex mental health needs. For maximum clarity, where possible, we have structured individual sections of this submission into ‘problem’, ‘impact’ and ‘solution’.

The submission begins by setting out areas where we feel the draft report should be reframed in order to better realise the Commission’s key aims around education, training and participation. It focuses on the essential components to improving mental health, with an emphasis on what we believe is a mismatch between what the bulk of the health care system is structured to deliver and the actual nature of need for those with mental ill health, particularly at the serious end of the spectrum, and the workforce best equipped to deliver this. The submission will examine the areas of housing and homelessness, income support, psychosocial disability support services in the context of service gaps in the NDIS, justice, and education, training and government support to find a job. The final section will look at how to better configure the mental health system, particularly the provision of social and psychosocial components, to those with severe and persistent mental ill health in and outside the NDIS.

2. Framing the inquiry's focus and assessment approach

The Inquiry's central pre-occupation is improving participation for those experiencing mental ill health and the potential productivity benefits from this. The Organisation of Economic Co-Operation and Development (OECD) estimates that mental ill health costs the Australian economy AUD\$28.6 billion a year, the equivalent of 2.2% of GDP.² Adding indirect costs, such as productivity loss or sickness absence, nearly doubles that amount. The OECD contends that people affected by mental ill health in Australia are three times more likely to be unemployed compared to those who are not. In addition to the impact on workplace productivity, we note that the costs of unmet need and poorly targeted services or ineffective services, particularly when the needs and current services responses for people with medium-high, high and complex mental illness are taken into account.

We also support the Commission's focus on children and young people due to the impact of mental ill health on education and early employment and the potential for this to have a detrimental effect in adult life. This is consistent with other OECD reports, which stress the importance of early intervention to head off the risk of early onset disadvantage from mental health issues and limit the risk of long-term unemployment.³ The OECD's approach is linked to a larger analysis of how modern job requirements place a higher value on social skills and cognitive competencies, which make labour market participation increasingly difficult for workers who are marginalised, including through mental ill health.

At the same time as acknowledging the very real debate around whether full employment is achievable in Australia, Mind strongly agrees that improved participation in education, training, voluntary work and the paid workforce is of vital importance for people experiencing mental ill health and, importantly, their families and carers. However, some reframing in the draft report is necessary to avoid what the Commission itself has identified as the lack of success of previous reform efforts. We believe such a reframing will also help the Commission to better realise its key aims around education, training and participation. This reframing, which cuts across more than one of the areas discussed in this paper, includes the following:

(a) A greater emphasis on the social and economic determinants of mental health.

A clear emphasis on the social determinants of mental health in the draft report would be of benefit to future reforms coming out of this inquiry. We would like to see policy and program solutions seek to remedy inequities in social and economic determinants (for instance, housing,

² Organisation of Economic Co-Operation and Development, *Mental Health and Work: Australia*, December 2015.

³ Organisation of Economic Co-Operation and Development, *Sick on the Job? Myths and Realities about Mental Health and Work*, January 2012.

education, employment, health) in equal measure to those that deal with the treatment and management of the symptoms of mental illness.

While the Issues Paper has moved considerably from the narrow and deterministic medical and health focus of previous inquiries into mental ill health, its mental health services model retains a primary focus on the type of interventions that address people's medical and clinical mental health needs, rather than the practical and emotional social supports they require to lead a more productive and fulfilling life. Social and emotional supports, whilst identified, are seen as separate to 'mental health' interventions. We argue for a conceptual framework that places the treatment and management of symptoms of mental illness alongside interventions that deal with the impacts of those symptoms on people's lives. A response to mental ill health should be based on an understanding that people with severe and persistent and/or complex mental illness need clinical treatment, medical care, psychosocial and social support all as part of their health need. Previous approaches have treated clinical, psychosocial and social supports as if they are separate things. Whilst this may be the case in terms of funding and delivery systems, it is not the case for many people with a lived experience of severe and persistent mental illness. Without equitably funded, integrated programs, co-ordinated at the individual level, anticipated gains will not be delivered.

The World Health Organisation has noted that mental health is shaped to a great extent by the social, economic and physical environments in which people live.⁴ In particular it has stressed that social inequalities are associated with increased risk of many common mental conditions. Not only is comprehensive action across life course required, but these interventions must focus on population subgroups that are at higher risk of mental ill health because of a greater exposure and vulnerability to unfavourable social, economic, and environmental circumstances, interrelated with factors, such as gender.⁵

This approach informed the recent New Zealand inquiry into mental health and addiction, and some of its framing and conclusions may be useful for the Commission.⁶ Like Australia, New Zealand has had no shortage of government inquiries and reviews in the mental health space, and the most recent inquiry was prefaced on the very clear recognition that the authorities were not getting the outcomes they desired despite considerable public investment. Of particular relevance to the Commission's framing of the inquiry, are two key themes that run throughout the New Zealand report:

- A very broad terms of reference, including mental health problems across the full spectrum of conditions – from mental distress to enduring psychiatric illness, and a mandate to look beyond the health system and health issues for answers, including a much clearer articulation of the social determinants that influence mental health outcomes.

⁴ World Health Organization, *Social Determinants of Mental Health*, 2014.

⁵ Ibid, 9.

⁶ *He Ara Oranga: Report on the Government Inquiry in Mental Health and Addiction*, November 2018.

- Consensus on the need for a new direction emphasising ‘wellbeing and the community’, with more prevention and early intervention, expanded access to services, more treatment options, treatment closer to home, indigenous specific and community based responses and cross government action.

As the New Zealand inquiry’s report put it: ‘We have deliberately taken a ‘people first’ approach in writing this report, being guided by the needs of people and communities rather than the preferences of the various groups accustomed to the way the system is structured and services are delivered at present.’⁷

A deeper focus on the social and economic determinants of mental health is in line with broader shifts in thinking about mental health, that have significant implications for the number of people who need support, the provision and funding of services for them, and what organisations may be best placed to deliver them.

The term ‘psychosocial disability’ has only been widely used in Australia in the last decade, and particularly with the introduction of the NDIS has overtaken the earlier term ‘psychiatric disability’. As Carol Harvey and her colleagues note, the term ‘psychosocial disability’ emphasises the social consequences of disability rather than the impairment associated with ‘psychiatric disability’.⁸ The National Mental Health Consumer Care Forum (NMHCCF) provides a good description of ‘psychosocial disability’ in their 2011 report, *Unravelling Psychosocial Disability*:

*Psychosocial disability is the term that mental health consumers and carers use to describe the disability experience of people with impairments and participation restrictions related to mental health conditions. These impairments and participation restrictions include loss or reduced abilities of or reduced abilities to function, think clearly, experience full physical health and manage the social and emotional aspects of their lives. The best outcome for people experiencing such disability will be achieved through supports that mitigate the effects of impairment or participation restriction and enhance the social and environmental opportunities to expand their capabilities.*⁹

The NMHCCF notes that, when understood through this inclusive lens, the number of people with psychosocial disability who need support is larger than the modelling undertaken by the Productivity Commission for its 2011 report on disability care and support.¹⁰ The Harvey paper outlines the ‘common set of difficulties which lead to complex needs’ as follows:

⁷ Ibid, 8.

⁸ Carol Harvey, Lisa Brophy, Samuel Parsons, Kristen Moeller-Saxone, Margaret Grigg, Dan Siskind, ‘People living with psychosocial disability: Rehabilitation and recovery informed service provision within the second Australian national survey of psychosis,’ *Australian and New Zealand Journal of Psychiatry*, Vol. 50, No 2 (2016), 534-547.

⁹ National Mental Health Consumer and Care Forum, *Unravelling Psychosocial Disability*, 2011, 16.

¹⁰ Productivity Commission, *Disability Care and Support Productivity Commission Inquiry Report*, Vol 1, No 54, 31 July 2011.

Typically, they have more severe illness characterized by frequent relapses and active treatment-resistant symptoms, severe negative symptoms, cognitive impairments and co-morbid mental health problems, such as substance misuse. Consequently, they more often require supported accommodation. Most have physical health problems due to a combination of poor diet, inadequate exercise, smoking, unwanted effects of medication and economic disadvantage.¹¹

Harvey et al note that the change in practice and language is conceptually problematic as the concept of psychosocial rehabilitation establishes goals for everyday function, such as housing and employment, that are different from recovery oriented goals, i.e., to lead a life of purpose, meaning and hope, despite the presence or otherwise of symptoms of mental illness. As William Anthony from Boston University, defines it

Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.¹²

While current policy settings dictate that all mental health services are 'recovery-oriented' whether delivered in the clinical or in the NGO setting, Harvey et al note that the latter sector is more explicitly funded to deliver psychosocial rehabilitation and recovery support. They also note that historically these services have been separate from mental health treatment services, the cause of much of the fragmentation that the current inquiry hopes to address.

Mind contends that the national frameworks that guide recovery-oriented practice in all mental health service settings have been more effectively implemented in the NGO/psychosocial settings. The medical model that still guides most clinical services, where knowledge and practice is dominated by professional ways of knowing about mental illness and recovery (focused on symptom reduction).

(b) The importance of not losing focus on the hard to deal with cohort of people suffering mental ill health

We are keen to ensure that the needs of people with severe and persistent and/or complex mental illness, and who experience unpredictable or episodic cycles of mental ill health are given due consideration within the Commission's broad scope of inquiry. We note that all severe and persistent mental illness is to some extent episodic. Across various low prevalence disorders, an unremitting course of illness is relatively rare with the majority of people

¹¹ Harvey, et al, 535.

¹² William A Anthony, 'Toward a Vision of Recovery for Mental Health and Psychiatric Rehabilitation Services', Boston University, Centre for Psychiatric Rehabilitation, 2007, 7.

experiencing some to good recovery between episodes.¹³ This evidence review found that early age of onset and co-occurring symptoms of depressions were supported as predictors of illness course and outcomes.

While the number of people with severe and persistent and/or complex mental illness may be relatively small in comparison to the general population and the spectrum of mental health in Australia, it is in relation to this cohort where the major public savings are to be made in terms of health care, housing and social welfare. Taking the focus off the most socially isolated and marginalised of those with mental illness not only risks the further deterioration of their health but could result in significantly greater service system costs in the long term, as their needs defray to more and more costly tertiary systems. This is a point that is reinforced by 2014 KPMG modelling of mental health outcomes commissioned by the NMHC.¹⁴

While the OECD report, *Sick on the Job?*,¹⁵ which appears to have had considerable influence on the Commission, recognises unemployment is bad for mental health, it does not display a fully informed understanding of the structural and social barriers that those with significant mental health issues face in order enter or re-engage with the education, training and employment. These barriers include social isolation, stigma, and the unpredictable and episodic nature of mental illness, which can impact an individual's ability to engage in the workforce.

Mind believes excessive focus on the mild to moderate cohort fails to fully consider the potential gains of focussing on people at the severe and complex end of the spectrum. Overlooking this cohort also fuels misconceptions about the nature and risks factors behind mental ill health, and disguises the political, social and economic dimensions that often underpin and exacerbate mental ill health, such as poverty, housing insecurity, and social exclusion. In addition, it fails to take account of precursors in childhood, such as violence, abuse and neglect, especially when these are intergenerational. Harvey et al note that childhood trauma and adversity are common amongst this cohort, and if unaddressed, may lead to poorer functional outcomes¹⁶.

Trauma is a theme in two current research studies that Mind is leading. The first, 'Understanding people with psychosocial disability as choice-makers in the context of the National Disability Insurance Scheme (NDIS)', in the process of being published, looks at people's experiences of choice and choice making in the context of the Scheme¹⁷. The second, '*Trajectories*: the interplay between mental health and housing pathways', which is in progress,

¹³ Nicholas A, Reifels L, King K, Pollock S, Mental health and the NDIS: a literature review – an examination of the current state of evidence relating to the impact of psychosocial disability on the context of the implementation of the NDIS Act 2013, Centre for Mental Health University of Melbourne, Mind Australia 2014

¹⁴ KPMG, *Paving the way for mental health: The economics of optimal pathways to care*, National Mental Health Commission, November 2014.

¹⁵ OECD, op cit, 2012.

¹⁶ Harvey, et al, 545

¹⁷ Wilson E, Campain R, Pollock S, Brophy L, Stratford S, Understanding people as choice-makers within the content of NDIS, Mind Australia 2019 (in press)

examines the intersection between mental ill health and housing insecurity. The former has found that historical and ongoing trauma limits people's capabilities as choice-makers, and particular attention is required to ensure that the conditions for choice making are accessible to people with psychosocial disability. This has important implications if choice in public policy is to be expanded for people from marginalised and excluded groups. Emerging findings from the *Trajectories* study appear to indicate that trauma plays a major role in formulating what is a safe sustainable tenancy. Without further regard to trauma, and development of trauma-informed responses, we contend that service offerings will remain fundamentally inefficient, failing to reap productivity gains that would be made available through embedded trauma-informed practice.

We would also like to highlight the real and serious intersection between serious mental illness and disadvantage and discrimination on the basis of race, gender and sexual identity. To elaborate on just one example that Mind is familiar with from its work, there are linkages between mental ill health and the multiple forms of stigma and discrimination that LGBTIQ people face.

Sufficient attention on the needs of people with severe and persistent and/or complex mental illness is required to fully develop and fund services that can assist them. These include psychosocial interventions of the type discussed in the previous section, the expansion of home and community based services, promoting a continuum of care, access to social, legal, and other long-term social and supporting services and rights protections for the vulnerable. A comprehensive literature review commissioned by Mind and undertaken by the Melbourne University Centre for Mental Health in 2016, confirmed a strong evidence base for the success of targeted psychosocial interventions in promoting recovery, particularly if they are applied early.¹⁸ The interventions that received a high endorsement in the literature were:

- Social skills training
- Supported employment
- Family psycho-education and support
- Outreach treatment and support services
- Cognitive remediation
- Cognitive behavioural therapy for psychosis
- Illness self management
- Supported education
- Supported housing
- Physical health management
- Peer support/consumer networking

¹⁸ Laura Hayes, Lisa Brophy, Carol Harvey, Helen Herrman, Eoin Killackey, Juan Jose Tellez, *Effective, evidence-based psychosocial interventions suitable for early intervention in the National Disability Insurance Scheme (NDIS): promoting psychosocial functioning and recovery*, University of Melbourne Centre for Mental Health, Melbourne School of Population and Global Health, and Mind, September 2016.

Of these interventions, the evidence base is particularly strong for personal choice and recovery outcomes, social skills training, supported employment and supported housing, to reduce future support needs.¹⁹ They also meet commonly expressed needs and goals for people with mental ill health and support personal recovery.

(c) Improved outcomes for unpaid mental health carers

While the Issues Paper notes the role and unmet support needs of unpaid mental health family carers, this group needs more focus. Mind maintains there are significant productivity gains and costs savings to be secured for employers and the public purse from policies that bridge the increasing gap between unpaid care and participation in work, education and training. This is a central issue that cuts across a number of the areas being examined by the Commission. Since 2018, Mind has led *Caring Fairly*, a national campaigning coalition driven by unpaid carers, and specialised organisations and peak bodies that support and advocate for improving the economic, social and cultural rights of all unpaid carers in Australia, including mental health carers. Caring Fairly is making a submission to the Commission's inquiry and Mind is keen to re-emphasise a number of its recommendations in this submission.

The last few decades have seen a shift away from the provision of health and community services in institutional settings in favour of care in the home and community. While this has many positives, it has resulted in a growing structural reliance on systems of unpaid care. Friends, neighbours, family members and sometimes even young children and adolescents are increasingly being called on to provide unpaid mental health care, usually within the family home. At an individual and familial level, the costs of Australia's structural reliance on such systems of unpaid mental health care can be significant. Mental health carers routinely experience diminished economic security, reduced career and employment prospects, as well as negative impacts on their own health and wellbeing. The effects on mental health carers are especially pronounced given the particular challenges they face compared to other 'carer cohorts', including:

- The younger age of onset of mental ill health compared to conditions such as cardiovascular, musculoskeletal and neurological disorders, meaning the economic impact of caring for someone experiencing mental illness can occur for longer.
- Fluctuations over time in duration and intensity of needs, making it more unpredictable, which in turn can vary the level and nature of care support required.

At the macroeconomic level, there are extremely significant social and economic costs to our current public policies around unpaid carers for people living with the impact of mental ill health. These should be of concern to the Productivity Commission.

There are an estimated 2.7 million unpaid carers in Australia, of whom some 850,000 have an intensive primary care responsibility that extends far beyond what has been 'traditionally expected', or outside of contemporary family norms.²⁰ Recent research commissioned by Mind,

¹⁹ Hayes et al, 2016, 20.

²⁰ Australian Bureau of Statistics, *Survey of Disability, Aging and Caring*, 2015.

and undertaken by the University of Queensland's (UQ) School of Public Health from 2016²¹ to 2018²² has revealed pivotal new insights into the extent, replacement costs, and opportunity costs of Australia's structural reliance on systems of unpaid care in the mental health space.²³

Specifically, these two interconnected studies found:

- There are, by conservative estimates, at least 240,000 mental health carers in Australia, including approximately 54,000 primary mental health carers.
- Mental health carers provide an estimated 208 million hours of informal care per year. The total annual replacement cost for all informal mental health carers was \$14.3 billion, as at 2015.
- Over 40% of working age mental health carers are either unemployed or not in the labour force.
- 47% of primary mental health carers who are not currently employed were working prior to commencing their caring role. This rate is similar across primary carers for all types of conditions.
- Over half (54.3%) of employed primary mental health carers aged 15-64 years have a possible need for more employment related support to maintain, improve or re-enter employment based on the available indicators.
- Over half (57.1%) of primary mental health carers who are not employed have a possible need for employment related support based on having left employment to commence caring, or wanting to work while caring.
- Young mental health carers may be disadvantaged in terms of participation in education and employment compared to other young people of the same age. School attendance for mental health carers aged 5-14 is significantly lower (87.2%) than for other carers.

While improving the situation of unpaid mental health carers is a complex, long-term challenge, it is also core to achieving better outcomes in a number of the areas identified by the Issues Paper. There are also significant productivity gains and savings in government expenditure to be achieved through increasing their participation in work, training and education.

(d) A greater role for people with lived experience of mental ill health and recovery.

Mind believes that mental health policy has not paid enough attention to the experience and management of mental ill health from the perspective of people with lived experience. Whilst the inclusion of 'lived experience' has been in policy for more than 20 years, in terms of

²¹ Sandra Diminic, Emily Hielscher, Yong Yi Lee, Meredith Harris, Jaclyn Schess, Jan Kealton, Harvey Whiteford, *The economic value of informal mental health caring in Australia: technical report*, University of Queensland School of Public Health, 2016

²² Sandra Diminic, Emily Hielscher, Meredith Harris, *Understanding factors associated with Australian mental health carers' employment: technical report*, University of Queensland, School of Public Health, 2018.

²³ Sandra Diminic, Emily Hielscher, Yong Yi Lee, Meredith Harris, Jaclyn Schess, Jan Kealton, Harvey Whiteford, *The economic value of informal mental health caring in Australia: technical report*, University of Queensland School of Public Health, 2016.

implementation, people with lived experience of mental ill health and recovery are often not included in decision-making fora, and their ways of knowing marginalised. We contend that a greater focus in the draft report on practical measures to ensure the inclusion of people with lived experience as equal participants in ongoing system development would assist in overcoming some of the challenges that have beset previous attempts at reform.

A similar situation arises in relation to the mental health peer workforce. The use of peers has been a growing part of Mind's philosophy and operations since the 1990s. Whilst Mind is still developing our strategies and practices to ensure that our peer workforce operates safely and effectively, we note that the peer workforce has immensely enriched Mind's practice and impact, and has led to very real service improvements and demonstrably better health and social wellbeing outcomes for clients. Mind echoes one of the overall conclusions of a recently published book on peer work that, within the context of reforms to the mental health system, we need to conceptualise the elements of peer work activity not just as a valued support activity for people experiencing mental ill health but as a developing service modality.²⁴ Peer work has proven effective as a cost effective complement to clinical services and an effective standalone intervention, with better outcomes and quality of life for consumers of mental health services.

²⁴ Janet Meagher, Anthony Stratford, Fay Jackson, Erandathie Jayakody, Tim Fong, *Peer Work in Australia: a new future for mental health*, Richmond PRA and Mind Australia, 2018.

3. Contributing components to improving mental health and well being

3.1 Why have past reform efforts by government had limited effectiveness in removing the structural weaknesses of healthcare for people with a mental illness?

The administration and funding of Australia's mental health system is split between Commonwealth/state/territory governments, as well as spread over a number of departments and statutory bodies at different levels. As the Issues Paper notes, major problems occur at a number of points in this interface:

- Between different locations of service provision: the emergency department and acute inpatient services, specialists and GPs, clinic mental health services, and the community managed sector (home and community based services).
- Between different approaches to reduce or remove symptoms and psychosocial wellbeing and interventions to enhance life in the home and community.
- Between mental health and other service systems, such as housing, homelessness, justice, education and employment.

Mind believes there is a great deal of what might be termed 'romantic thinking' around how the mental health system has been conceptualised prior to the advent of NDIS. We need to be clear that many of the problems and the unmet demand currently attributed (by some) to the NDIS existed before it came into being.

That said the NDIS implementation has been a disruptor. It has created significant challenges for consumers and their carers, has introduced delays, created gaps and exacerbated unmet demand for services in some areas. It has impacted on patterns of service access and use, on occasion leaving those who have had (and needed) long term support without assistance, and at other times, enabling people previously unknown to mental health services to receive large funding packages. Albeit well-intentioned attempts by government to plug gaps and meet demand, such as funding for community mental health services commissioned through Primary Health Networks (PHNs), has only made the situation more complex. NDIS has effectively drawn a line down the middle of the Commonwealth/state/territory mental health services, especially in areas such as housing, which we will examine later, and exacerbated differences between jurisdictions. For example, figures from the National Disability Insurance Agency (NDIA) reveal that an average NDIS plan for an individual with a psychosocial disability is \$60,000 nationally, but only \$40,000 in Victoria, although we are unclear exactly why this occurs.²⁵

²⁵ These figures are sourced from two reports, the national and Victorian NDIS, *COAG Disability Reform Council Quarterly Performance Reports* for December 2018. The figure of \$60,000 comes from page 29 of the national report. The figure of \$40,000 comes can be found on page 28 of the Victoria report.

While previous inquiries have identified many of these problems, including system fragmentation, limited coordination, and services focused on the needs of providers rather than clients, as the Commission notes, the recommendations have failed to make Australia's mental health system simpler and more effective. Mind believes that at least some of the limited effectiveness of past reform efforts can be blamed on the lack of attention paid to the social and economic determinants of mental health, and measures to ameliorate these. This has privileged service responses that address people's medical and clinical mental health needs and the symptoms of mental illness and disorder. Psychosocial and social supports that aim to assist people with the practical and emotional support they need to gain/regain a productive and meaningful life remain thin on the ground and the skilled psychosocial workforce is leaving the community managed sector due to funding limitations and the drive to more efficient with the public dollar. One very clear example of how this dominant medical focus has influenced service provision is captured in research that reveals funding to acute services has outstripped resources allocated to community mental health services in Victoria.²⁶ The dominance of the medical model, has also manifested in who has been given a seat at the table around mental health debates and who has been excluded, i.e., carers and people with lived experience, skewing the conversation and further reducing the impact of reform efforts.

There are also valuable insights to be gained from the work of University of Sydney academics, Sebastian Rosenberg and Ian Hickie, who maintain past reform efforts have faltered not only due to the lack of attention paid to the social and economic dimensions of mental ill health, but because of the limited data available to make comparisons and measure progress. They contend that this situation, which reflects the acute health focus of much of mental health data collection locally and internationally, renders us 'largely outcomes blind'.²⁷ This, in turn, has been reflected in Australia's relatively poor outcomes in relation to the high rates of mental ill health among prison inmates and the unemployed, and the significant incidence of co-morbidities such as obesity, and rehospitalisation of people with schizophrenia. Elsewhere, Rosenberg and others have noted Australia lacks data in crucial areas such as the prevalence of stigma, service affordability and gaps, and the sustainability of the mental health workforce, many of these issues being examined by the Commission.²⁸

The key question posed from this analysis is how the Commission can embark on effective reform without basic data on which to base policy solutions and map their effectiveness over time. Obviously, the issues involved in effective data collection are long term and involve numerous factors out of control of the Commission. It might be useful for the Commission to

²⁶ Ruth Vine and Fiona Judd, 'Contextual issues and implementation of mental health legislation,' *International Journal of Law and Psychiatry*, January-February 2019, Vol.62, 16-19.

²⁷ Sebastian Rosenberg and Ian Hickie, 'No gold medals: Assessing Australia's international mental health performance,' *Australian Psychiatry*, Vol 27(1), 2019, 36-40.

²⁸ Sebastian Rosenberg, Ian Hickie, Patrick McGorry, Luis Salvador-Carulla, Jane Burns, Helen Christensen, John Mendoza, Alan Rosen, Lesley M Russell, Sally Sinclair, 'Using accountability for mental health to drive reform,' *Medical Journal of Australia*, 203 (8), October 2015, 328-330.

develop a set of desired indicators against which to assess mental health reforms. Rosenberg and others have suggested eleven indicators that help the Commission to do this work.²⁹

- Suicide rates: attempts and completions.
- Death rates after discharge from any mental health facility and cause of death.
- Prevalence of mental illness.
- Employment participation by working age people with mental ill health.
- Participation rates by people with mental illness 16-30 in education and training.
- People with a mental illness in stable housing.
- Community attitudes to mental illness.
- Consumer and carer experience of care.
- Hospital readmission rates.
- Life expectancy for people with severe and persistent mental illness.
- Numbers accessing specialised programs to enhance economic and social recovery.

Rosenberg et al also recommend that governance of the collection of data should reside in a body suitably independent from government, akin to the role played by the New Zealand Mental Health Commission. The Productivity Commission may find value in examining the supporting rationale behind the recommendations of the New Zealand inquiry into mental health.

A system that will deliver improved outcomes for people with severe and persistent and/or complex mental illness should:

- Provide a continuum of care across urban/remote/regional areas.
- Incorporate a single, nationally consistent approach to assessment of needs for those people with mental health issues who need more than medical and clinical treatment in order to participate and live a meaningful life.
- Include supports for individuals to navigate across national/state/territory jurisdictions and between the parts of the system, clinical care, community managed care, and emergency department/acute inpatient hospital care.
- Recognise the ubiquitous challenges of those with mental ill health and how this can relate to needs such as housing, income support, labour market participation, etc., and ensure that these are included in any recovery-focused mental health assessment.
- Better recognise the unique experience of particular groups with mental ill health, such as Indigenous Australia, LGBTIQ, people from multicultural and multi-faith communities, refugees etc.
- Recognise and assist the work of unpaid carers for those with lived experience of mental ill health, and as part of this increase debate around the lack of fairness and sustainability of income transfer and entitlement programs.
- Deal with shortfall in service provision created by the roll out of the NDIS.
- Generate the necessary information to allow for benchmarking, monitoring and evaluation.

²⁹ Ibid.

3.2 Contributing components to improving mental health and wellbeing: healthcare

Problem:

The description of the healthcare system for supporting mental health in the Issues Paper demonstrates that the current investment profile is clustered around types of support that address people's medical and clinical mental health needs, mainly in the hospital setting and associated outpatient/community treatment. These forms of intervention address the symptoms of mental illness and disorder, but do little to assist people with the practical and emotional support they need to gain/regain a productive and meaningful life. In particular, not enough emphasis is placed on psychosocial support that people need in order to address their social and economic barriers to participation, nor to access assistance with various social problems from, say, the wider community services sector or indeed, from the universal service sector.

There is a lack of distinction between a psychosocial disability support need funded by NDIS and a psychiatric/psychosocial need funded to reduce admissions and emergency department visits. The defunded Psychiatric Disability Rehabilitation Support Service, historically provided disability supports to people with functional impairment related to mental illness. The funding was rolled into the NDIS. Also rolled into the NDIS were other psychosocial support programs providing assistance to people with mental illness and lower levels of need, such as Personal Helpers and Mentors Scheme (PHaMS), and the specialized care co-ordination program, Partners In Recovery (PiR). It is now widely recognized that there is significant funding limitation to meet the support needs of people with mental illness who are not eligible for NDIS, or who do not want or able to apply.

Impact:

Compared to the stepped care model on page 13 of the Issues Paper which provides a description of the population mental health care need, tiered on level of need, a mismatch appears between what the bulk of the healthcare system is designed to deliver (clinical and medical assistance) and the nature of need.

The stepped care model places significant emphasis on psychosocial and social supports, care co-ordination and navigation, and includes a range of 'non-health' supports including housing, education, disability, social security, etc. This is particularly the case for 'high' and 'complex' needs categories. Whilst the stepped care model describes a range of supports as 'non-health', for those people with high or complex needs, these 'non-health' supports are in fact a precursor to gaining/regaining the good health that is required to be a productive and functioning member of society. For instance, it is not possible to recover from a severe or prolonged mental illness without safe and secure housing. In order to increase the productivity and participation of those in the high and complex needs categories, consideration should be given to addressing their housing, education and health needs as necessary precursors to wellness (i.e., as health

needs). This can be done effectively and efficiently through programs delivered by community and social care providers working in partnership with primary care and acute clinical providers.

In addition to the system design principles set out on page 16 in this response, Mind argues that a holistic mental health response is required, and includes:

- Prevention and mental health promotion at a whole of population levels, focusing on child and family mental health.
- A response to the whole person rather than just the symptoms of their illness.
- Clinical and medical treatment that takes account of people's physical health, as well as their mental health.
- Rehabilitation to help people recover after prolonged periods or severe episodes of illness (comprising a combination of clinical and psychosocial rehabilitation support).
- Long term social and support services for those who are severely and/or persistently impacted by mental illness, including those for whom the impact is episodic (again comprising a combination of clinical and psychosocial support, the latter focussed on building people's capacity for independence but titrating where ongoing assistance might be required).

Examined from this perspective, Mind argues that an entire component of what is needed for a comprehensive mental health response – rehabilitation and longer term social support understood as part of the mental health recovery need - has largely disappeared from the system configuration. We argue that this specific need has been conflated with the psychosocial disability support need, which it is intended the NDIS will address.

To gain some understanding of the size of this gap, we refer the Commission to work undertaken by Mental Illness Fellowship of Australia (MIFA), who estimates there are at least 290,000 people who have reduced functional capacity on the basis of severe and persistent mental illness (ie psychosocial disability) and who need a broad range of psychosocial and social supports, as well as clinical and medical treatments. In addition, there are a further 690,000 with severe mental illness who have some level of psychosocial and social support need that is unaddressed, or inadequately addressed in current system configurations. We understand this analysis will be reported in detail in the MIFA submission to this inquiry.

Finally, we note that if these social and psychosocial needs remain unaddressed, there are considerable cost implications, as people's conditions will worsen, requiring responses from costlier tertiary systems, in particular, hospitals, homelessness, and criminal justice. Equally, a lack of timely support for these cohorts will carry an opportunity cost, as people fail to recover and participate.

Solution:

The home and community based services delivered by the community sector, more than any other part of the mental health system, suffer from a lack of evidence to support the outcomes

it achieves, a fact also noted by Rosenberg and Hickie.³⁰ With its roots in localized and voluntary services addressing unmet need (for instance, housing for people with severe and persistent mental illness in the 1970s), the sector has not been required nor, it is important to add, funded to build an evidence base for its practice in the same way that occurs in 'mainstream' health service delivery. Despite the lack of high quality independent evidence, we contend that community-managed organisations like Mind are well placed to address many of the psychosocial rehabilitation and disability support needs that people living with mental illness have.

Mind has done some work gathering customer feedback of its services. An independent report that Mind commissioned in February 2016 provides a snap shot of the challenges and aspirations of those with mental health and their carers who use Mind's services nationally, particularly in the context of our earlier discussion of the social determinants of mental ill health and the need for comprehensive psychosocial service interventions to deal with these.³¹ While the report identified areas in which the organisation can do better, it found that Mind's services were viewed as useful and needed. Particularly valued were empathetic and practical psychosocial supports, the breadth and depth of which are not in the remit or not adequately dealt with by other services such as PHNs. Consumers generally report a good experience of Mind's residential services and the organisation's one on one personal and clinical support. Importantly, carers also highly rated Mind's services, including giving them much needed social connection, an affirmation of their efforts, important information and respite services.

To meet these needs, we employ a diverse workforce. Our staff profile includes certificate-qualified mental health practitioners who provide step-by-step practical and emotional assistance to help people get back on their feet after a period of illness. Mind has a core of degree-qualified practitioners to provide complex care co-ordination and support facilitation, behavioural supports and other complex interventions. We also have registered allied health professionals (occupational therapists, psychologists, and mental health social workers) and a new program, which we shall discuss in more detail in section 3.11, which provides legal advice to consumers and their families. At times, we deliver assistance in partnership with clinical services to deliver integrated clinical and psychosocial care that results in strong recovery outcomes

This workforce brings together specialist (i.e., trained to undertake assessments, deliver and oversee targeted interventions) and specialised (i.e., trained to work with a particular cohort, delivering more generic skills) skill sets.

Mind would like the Commission to consider arrangements that support a mixed community-managed mental health sector workforce, covering allied health (including some clinical components), rehabilitation and disability support. We contend that the community-managed sector is well-placed to deliver appropriately governed psychosocial and clinical services (i.e.,

³⁰ Rosenberg and Hickie, op sit.

³¹ *The Key Response: Research Report*, Mind, February 2016.

clinical case management, mental health nursing) more efficiently than in the current separate sector model that separates out clinical and medical and NGO psychosocial support. Whilst our services are currently largely non-clinical, we argue that in future, consideration should include a NGO workforce that can deliver services under the Medicare Benefits Scheme (MBS), with GPs and psychiatrists as part of the team.

Mind suggests the Commission examine funding for innovative research projects, involving consumers and family/carers as well as service providers, to overcome the lack of detailed research on the outcomes delivered by community mental health services.

3.3 How does the professional mental health workforce need to change to improve where and how care is delivered?

Problem:

Mind believes an answer to the workforce issues raised by the Commission is most clearly articulated by viewing them within the framework of what is required in a workforce that can deal with the complex social determinants of mental ill health, who is best placed to provide the various components of this response, and what is required to support them to do it.

The greatest expenditure in terms of the mental health workforce is on the provision of services and supports that meet people's clinical and medical needs, in the form of treatments and therapies delivered by doctors (GPs and psychiatrists), psychologists, and mental health nurses. Properly valued, trained and remunerated community mental health workforces can efficiently and effectively service these needs.

The mismatch between need (particularly in relation to psychosocial rehabilitation) and the current configuration and capabilities needs to be addressed in future workforce planning to give greater emphasises to addressing social determinants and rehabilitation needs. The current configuration of commissioning models, short-term contracts and delays in contracting, and short notice periods for contract end dates, is combining to create uncertainty for workers, evident in the rising sick leave, turnover rates and difficulties attracting, recruiting and retaining staff. The changes to funding and program arrangements that have occurred as a consequence of the introduction of the NDIS mean this workforce is now seriously under threat. We risk losing a whole section of capability that, in terms of the stepped care model on page 13 of the Commission's Issues Paper and in line with the focus on social determinants throughout the issues paper, is a key part of the configuration of the future mental health workforce.

An insight into how this situation is impacting workforce and service provision can be seen in the current funding and contracting arrangements for the provision of psychosocial services by PHNs. Introduced to replace Medicare Locals and administered by the Department of Social Services (DSS), PHNs have been funded to cover the gap created as services were rolled into the NDIS, for those not in the Scheme but who continue to need psychosocial support and stepped care. The administration of the scheme, small amounts of funding, dispersed over

relatively tight time frames (one to two years initially although this has since been expanded), with very tight KPIs, has had several detrimental impacts on service providers. The small amount of money, spread across the entire PHN network, combined with unrealistic expectations, has made the job of providing a sound service, in Mind's view, unviable. The low funding level, combined with the short time frame of contracts, has also made it impossible to recruit and train the qualified staff. Further complicating this situation, there is a lack of coordination in certain jurisdictions, such as Victoria, resulting in a plethora of service models and no continuity of care. Given the organisational and financial problems involved with the model, Mind made the decision not to tender for it any further.

The situation is reaching a critical juncture. Put simply, the NDIS and associated policy and program changes have placed the community mental health workforce in jeopardy. Across the community-managed sector, it is becoming harder to attract, recruit and retain people with the appropriate capabilities. We are at risk of losing a whole segment of the workforce with the capabilities to address the social determinants of mental health and assist people to connect and reconnect with meaningful and productive activity. These capabilities are a mix of generic social services skills and an ability to work effectively with people with serious mental health challenges. The specialised psychosocial disability stream being introduced into the NDIS has come about because it is now recognised that generalists cannot effectively provide supports to people with psychosocial disability, and that specialised capabilities are required to achieve the outcomes that individual and policy makers each seek.

Impact:

We believe the loss of workforce capability is already impacting on new programs being rolled out under the PHNs and continuity of support arrangements. As the NDIS is bedded down, a better understanding is emerging of what service gaps exist; particularly those focused on mental health rehabilitation and addressing social determinants, across the system. However, it is likely to take another three to seven years or so before the system configuration implications of the NDIS are fully understood. As the Issues Paper makes clear, a greater focus is required on social determinants of mental health, and the social and psychosocial barriers to participation and productivity. But if the capabilities of the community-managed workforce are inadvertently eroded in the interim period, there will be a significant human and financial cost to rebuilding them.

The loss of the community-managed workforce will impact adversely on hospital avoidance in Step-Up Step-down services (SUSD) (known as PARCs in Victoria) and where psychiatric rehabilitation requires a partnership of clinical and psychosocial team based care, delivered as an integrated response and allowing the various professionals to work at the top of their scope of practice. Diminishing capabilities in this workforce will also impact on our ability to innovate.

Future configurations should consider the possibility that some service elements (for instance, clinical case management, assertive outreach and some community-based mental health nursing functions) currently delivered by costlier clinical services could and should be delivered

by an appropriately skilled and regulated community mental health workforce. Assessment of functional capacity, care co-ordination and system navigation are elements of a comprehensive mental health response highlighted in the stepped care model that could safely and efficiently be delivered by a community mental health workforce, along with some low intensity therapies, and therapies that combine a clinical tele/digital intervention with peer support. Mind has also, at times, employed mental health nurses and psychologists working within their specialist scope of practice, and sees opportunities to expand this provision in future.

Solution:

Mind encourages the Commission to examine the following:

1. The development of a multidisciplinary community mental health workforce strategy. This should consider the future functions that could be transferred to community provision, and the kinds of needs and regulatory frameworks required for this workforce to operate safely, fairly and effectively.
2. Greater investment in integrated models, and models that require a multi-disciplinary response, where the co-ordination is taken care of in the service design rather than by the individual trying to navigate a complex system.
3. Measures to streamline commissioning models and the associated compliance burden for community mental health organisations. As part of this, consideration should be given to where block granting, rather than competitive tendering, is more likely to produce the best population outcome and deal with personalization and individual choice within service design, rather than through individualizing funding.
4. A nationally consistent, standardised assessment approach, accessible through multiple referral points. This would provide a holistic, assessment undertaken in the individual's regular living context, and would take account of clinical and functional needs.
5. Assessment linked to consistent, standardised outcomes measures that reflect a social determinants approach to mental health and wellbeing, and focus on outcomes for individuals (for instance, the Citizenship measure developed by Rowe and colleagues in the USA³²).

3.4 What could be done to reduce stress and turnover among mental health workers?

Problem:

In addition to issues stemming from the combination of commissioning models, uncertain funding arrangements, underfunding and delays in contracts being announced, significant

³² Michael Rowe, Ashley Clayton, Patricia Benedict, Chyrell Bellamy, Kimberly Antunes, Rebecca Miller, Jean-Francois Peletier, Erica Stern, Maria J O'Connell, 'Going to the Source: Creating a Citizenship Outcome Measure by Community-Based Participatory Research Methods, *Psychiatric Services*, May 2012, Vol. 63(5), 445-450

problems result from the increasingly transactional nature of service delivery. This is where the cost of delivery is calculated on the principle of an 'efficient price' for transacting the support provided, without counting the cost of what it means to provide that service to someone with a psychosocial disability or serious mental health issue, including the capabilities and time required to deliver the service in relationship. The result is that the emotional labour, and support that are part of good psychosocial support are no longer a funded component of the work. This was clearly evidenced in Mind's 2016 customer research³³. They still occur but are unfunded, adding to people's workloads and emotional burden. This is also true of the kinds of liaison necessary between workers within a service and between different service systems and organisations, to ensure that support for any given individual was effective and contributed to positive outcomes.

In the individualised funding environment of the NDIS in particular, these kinds of work not valued or counted, adding to worker stress and resulting in a less effective support than previously. This is particularly the case when working with NDIS participants who have little or no Support Co-ordination in their packages, and too much front loaded low value core compared to Capacity Building (more generously funded, and therefore allows for more of the complex emotional work to be done as part of what is costed).

Impact:

Mind's annualised turnover rate (based on resignations) has run at around 22% for a number of years. However, in the last year, we have seen this increase to as much as 29% in some parts of our business where the impact of NDIS transition has been strongly felt. It costs Mind around \$30,000 to replace a frontline worker, in recruitment, training, getting up to speed etc. There is also substantial impact on worker wellbeing, with insecurity about job security and the stress of carrying the burden of uncounted emotional labour compounding each other.

We note that the impact of stress on the paid mental health workforce is replicated amongst unpaid carers. Any shortfall in service coverage or other system failure impacts on unpaid family carers in much the same ways as it impacts on the paid workforce. Yet unpaid carers lack the protections offered by paid employment contracts. They do not routinely access training to support the changing nature of the care work as the systems around them change. They generally are not consulted in change processes. Yet when system fails, it is often the unpaid carers who are left to pick up the pieces.

Solution:

Mind proposes the Commission examine the following:

1. Ensure that service models for people with psychosocial disability and for people who require rehabilitation following mental illness take full account of the specialized

³³ *The Key Response: Research Report*, Mind, February 2016.

- capabilities required to deliver effective and safe services to these cohorts of people. In other words, ensure that the emotional labour is captured in the efficient price.
2. The development and implementation of a single, nationally consistent approach to assessing the support needs of people with high-medium, high and complex mental illness (as described in the previous section). This would ensure that people receive appropriate support through the least intensive system, rather than testing eligibility against the NDIS as the first port of call.
 3. Extend the PHN rolling contract arrangements to community mental health organisations. Look for opportunities to streamline arrangements and reduce the burden of responding to tenders, as well as contractual compliance. Mind's current compliance and accreditation costs sit at around one million dollars on an \$80 million turnover.

We would urge the Commission consider the 2012 Australian Health Workforce Institute report on the role of carers and volunteers in the health workforce.³⁴ This contained a number of recommendations on how to better support and link carers into the health system. We urge the Commission to consider the needs of family carers in the same manner as the needs of a paid workforce might be considered. Section 3.6 contains further commentary on this issue.

3.5 How could training and continuing professional development be improved for health professionals and peer workers caring for people with a mental illness?

Problem:

The dominance of the medical model, among other factors, has stifled the development of a greater role for peer support as a viable mental health service modality, despite growing evidence of value. Australia remains dependent on traditional health professionals for care. For every 1000 full-time equivalent staff employed across mental health services, only 6.1 will be consumer or peer workers.³⁵ For NSW and Victoria this is lower than it was a decade ago. While it was hoped that the NDIS would open up opportunities for peers, the take up has been much slower than many anticipated. While we recognise the in NDIA's in principal commitment to incorporate peer work, the Agency has failed to clearly conceptualise how peers fit into the Scheme, including its outreach and community work.

More research needs to be done on why, in an emerging choice based market for disability services, more participants are not choosing to incorporate peer workers into their individual plans. Part of the reason would appear to relate to a much wider lack of understanding about the role of peer workers in the disability sector generally. Practice wisdom indicates this relates to the widespread perception peer workers can only provide one-on-one support to people experiencing mental ill health, whereas, as Mind conceptualises their role, they can do

³⁴ Peter Brookes, *The Role of Carers and Volunteers in the Australian Health Workforce: Caring in Partnership*, the Australian Health Workforce Institute, November 2012.

³⁵ Rosenberg, op cit.

everything that a non-peer does but from a peer perspective. Indeed, a 2014 Mind Australia evidence review set out a broad range of models that could be informed by peer work approaches, including community based interventions, group based mutual support, peer education, coaching and telephone based support.³⁶

Impact:

Through its failure to pay more attention to peer work, and develop workforce strategies and models to support its growth, the mental health sector is missing out on a crucial service innovation and the improved services outcomes and systems savings it could bring about.

Mind's commitment to peer work originated in the 1990s as part of a commitment to shifting its practice from what we might call 'professional led paternalism' towards peer led partnerships.³⁷ Mind currently employs 65 people in designated peer/lived experience roles. These individuals are employed at all levels of the organisation, and include consumer and carer peers. We note that our peer workforce has a lower annualised turnover rate than non-peer workforce (14%, compared to 21%), and they take less personal leave (including sick leave). We argue that this indicates that, when appropriately funded, a peer workforce can reduce costs as well as deliver improved outcomes.

There is an emerging evidence base pointing to the outcomes and cost effectiveness of peer work. In addition to the findings of the aforementioned 2014 Mind report,³⁸ a 2013 report by the UK Centre for Mental Health found that peer workers brought about significant reductions in bed use among the patients they supported, leading to financial savings well in excess of what it cost to employ them.³⁹ Other research has shown that not only can staff with lived experience function at the same level as non-peer workers, but that they can achieve a range of other positive benefits and outcomes for the people they work with. Examples include the successful use of peer mentors in working with people with serious mental ill health to cease smoking,⁴⁰ and the success of an on-line peer support program to reduce stigma, promote social connectedness and improve the wellbeing of individuals with mental health.⁴¹

Among the outcomes noted in a 2017 review of academic studies on peer work in mental health, were reduced hospital admission/re-admission rates, a reduction of alcohol and drug use, and

³⁶ Bell T, Panther G, Pollock S, *Establishing an effective peer workforce: A literature review*, May 2014.

³⁷ Erandathie Jayakody and Anthony Stratford, 'Peer work in Mind Australia,' in *Peer Work in Australia*, 71.

³⁸ Bell et al, op cit.

³⁹ Janet Meagher, Gerry Naughton, 'Scope, role and contribution of peer work: derived, synthesised and analysed from selected peer work literature,' in *Peer Work in Australia: a new future for mental health*, 24.

⁴⁰ Faith B. Dickerson, Christina L.G. Savage, Lucy A.B. Schweinfurth, Deborah R. Medoff, Richard W. Goldberg, Melanie Bennett, Alicia Lucksted, Matthew Chinman, Gail Daumit, Lisa Dixon, and Carlo DiClemente, 'The Use of Peer mentors to Enhance a Smoking Cessation Intervention with Persons with Serious Mental Illness,' *Psychiatr Rehabil*, March 2016, 39(1), 5-13.

⁴¹ 'Online peer-to-peer support in youth mental health: seizing the opportunity,' *Epidemiology and Psychiatric Sciences* (2016), 25, 123–126.

increased community integration and social inclusion.⁴² The review also noted better outcomes for carers, such as an improvement in relationships and support when carers were feeling excluded by services. There was also evidence of benefits from the bidirectional sharing of knowledge between clinicians and peer workers. Other benefits identified in the literature include:

- Greater rates of success working with 'difficult to reach' clients.
- Instillation of hope and the demonstrating to the patient that it is possible to being controlled by an illness to gaining some control over it.
- Role modelling- use of self-knowledge to better negotiate day-to-day life, including with mainstream human and social service providers.
- Creating relationships based on trust, acceptance, understanding and the use of empathy, better ability to 'read' a client.

Mind's experience is that the use of peer approaches has led to improvements in client independence and empowerment, reflected in increased stability in work, education and training. It has also played a major role in breaking down the stigma around mental illness. Consumers involved in peer support activities have higher levels of community integration and enhanced social functioning. Within the organisation it has resulted in important conversations related to job configuration and training, not just for peer workers but all staff. In addition, peers model good behaviour to staff in terms of management of mental health generally and make others comfortable to discuss issues involved in stress and burn out, etc.

Mind continues to develop in relation to its peer workforce. Nor are we the only organisation that is attempting to shift its practice and organisational structure to accommodate this emerging and important service modality. Some of the issues we have faced and continue to face, which may provide useful background for the Commission in its deliberations on how to better to incorporate peer work into mental health responses, include:

- The need for change at all levels of the organisation, including human resources and the configuration of position descriptions and jobs tasks.
- The challenge of configuring IT systems in such a way as to ensure peer workers exercise control over the disclosure of their mental health condition.
- Role clarity and position description drift. For example, there have been instances where someone with lived experience has created a peer position but it has only remained so while that particular individual is in the job and after they have moved on it has ceased to be filled by a person with lived experience. There have also been examples of people with lived experience moving into leadership positions but the management role not adequately incorporating peer perspectives and framework of working.

⁴² Frances Dark, Murray Patton, Richard Newton, 'A substantial peer workforce in a psychiatric service will improve patient outcomes: the case for,' *Australian Psychiatry*, 2017, Vol 25(5), 441-444.

- Stress, isolation and burnout for peer workers (although we would stress this is an issue for mental health workers generally).

One of the most serious issues we have identified is the lack of professional development, training and career path options for peer workers. There is only one specialised qualification, a Certificate IV in Mental Health Peer Work, offered through the TAFE/VET sector, specifically designed for people with a lived experience of mental illness to equip them to assist others in recover of mental illness. Mind has partnered with Swinburne University of Technology TAFE to support some clients and residents in its independent living facilities to undertake this course and the Certificate 4 in Mental Health, and to count placement activities with Mind as part of the assessment. A problem, however, is the lack of employment options upon graduation. The transitioning of PHaMS funding into the NDIS has exacerbated the situation. Introduced by the Commonwealth in 2006, Mind was one of the organisations that successfully tended for PHaMS and it played a major role in the evolution of our peer workforce. PHaMS consisted of five person teams, one of which had to have lived experience of mental health and recovery. This was the only government program that specifically mandated the employment of peer workers.

Solution:

As a starting point, the Commission may want to examine the successes and failures experienced by Mind and other community managed mental health in incorporating peer workers and perspectives. These are a number of detailed case studies in the previously cited book by Jayakody et al.⁴³ Frameworks have also been developed at the state level. The 2011 *Victorian Framework for Recovery Oriented Practice* is a good example, as it specifically recognises the value of a peer workforce and principles to underpin its creation, however, it has not been supported to have any measureable impact.

We believe there would also be value in the Commission examining the operations of the Mind Recovery College. Based on a UK model, the College is designed to advance Mind's recovery orientation focus and provide education-based mental health service achieved through the provision of education by people with and without a lived experience of mental illness. Among the positive outcomes identified in a 2016 evaluation of the College by the University of Melbourne was expanding the conceptualisation of employment possibilities for people with mental ill health, including greater knowledge of career options in peer support.⁴⁴ Mind is happy to provide the Commission with more details about the College.

⁴³ In addition to the two chapters previously cited in Jayakody et al, the Commission should examine Fay Jackson, Tim Fong 'Changing Culture and growing peer work', 43-68. The book also includes a number of contributions on the experience of peer work by states and territories.

⁴⁴ Teresa Hall, Lisa Brophy and Helen Jordan, *A report on the early outcomes of the Mind Recovery College*, University of Melbourne and Mind Australia, 2016.

In terms of specific suggestions, the Commission should:

1. Recommend funding for a lived experience advisory body and secretariat, separate of Mental Health Australia, which can advise government on mental health policy and strategy, as well as the development of models for an expanded peer review workforce.
2. Examine the feasibility of the NMHC and its state counterparts, where they exist, taking the lead and coordinating content for ongoing professional development for people with lived experience who seek to work as peers in the mental health sector. Ideally this would be done in tandem with increasing the employment of peer worker at all levels of mental health service delivery, including clinical and NGO services, and the NDIA. This could also assist with preventing burn out and make a longer-term career feasible for mental health peer workers.
3. Consider developing a graduate program that could place new graduates from relevant degree courses in a series of rotations in different components of the mental health system, over a two or three-year period. The Future Social Services Institute in Victoria is a good example of an initiative that combines research and workforce development across multiple community services sectors (disability, aged care, mental health) and recognizes the commonality of some capabilities, transportability of qualifications and possibilities for shared or pooled training. It also has PhD scholarships and bursaries aimed at up skilling the existing workforce

3.6 Better supporting unpaid mental health carers

Problem:

The persistent failure to recognise and value the contribution of unpaid mental health carers cuts across a number of the areas being examined by the Commission.

In addition to lost productivity and reduced government tax revenue from the lower workforce participation of carers, there are increased costs associated with their poorer health outcomes and reduced retirement savings for the carer. Employers experience lost productivity and lower returns on training investments when skilled employees exit the workforce, or have to reduce working hours, due to caring responsibilities.

The unsustainability of current modes of informal care for people with a disability, including those experiencing mental ill health, was a key part of the report from the Commission's 2011 inquiry into disability support care.⁴⁵ Early modelling was partly prefaced on the meeting the unmet demand for disability services and the impact this was having, not only on people with a disability, but their carers. It emphasised the unsustainable and unfair reliance on the unpaid work of informal carers, which would only become more unsustainable, the Commission claimed, in the face of demographic and others shifts which would lead to an anticipated decline in the availability of informal care in the coming years. 'Appropriate funding would

⁴⁵ Productivity Commission, 2011.

stabilise the withdrawal of informal carers under the present system which is leading to the costly withdrawal of informal supports by non-coping carers.’⁴⁶ The report also highlighted the need to increase the workforce participation of disabled people and their carers, and emphasised the projected public savings this would generate. The current situation of unpaid carers reveals how far the Scheme has drifted from its original intentions. The NDIS, as it is currently configured, fails to recognise the important role carers play in supporting those participating in the Scheme, even with the introduction of a specific ‘psychosocial disability stream’. The situation is even worse for the many carers who find the person they care not included in the NDIS framework.

Impact:

The situation of informal and unpaid mental health carers is part of a much larger challenge facing the many Australians trying to juggle unpaid caring with work, education and maintaining their health and social connectedness. We have already noted the outcomes of the research commissioned by Mind and undertaken by UQ.⁴⁷ Furthermore, the research highlights two ‘groups’ that are particularly adversely impacted by their unpaid caring responsibilities: women, and the young. More female than male mental health carers work part time (29.5% compared to 19.5% for men) or not at all (51.9% compared to 31.9% for men). Even more alarmingly, the UQ data shows that in contrast to male mental health carers, whether their care recipient received formal support services or not had no impact on employment prospects for female mental health carers. This underlines the importance of targeting policy interventions directly at the female carer as opposed to the person they care for.

Young carers, who may not identify with the term ‘carer’ or even realise they are engaged in a caring role, also face disadvantages in their participation in education and training. There is an emerging body of evidence that strongly suggests that children with a mental health caring responsibility, who are aged 5 to 14, are more vulnerable to disengaging from school than their peers. There are major long-term individual and societal impacts for the cohort of children with a mental health caring responsibility not attending school. The full extent of this problem is under-researched, and drawn from intrinsically limited government data sets. Mind is currently designing a research methodology to further investigate this issue. More details on the known parameters of this problem can be found in Mind’s 2018 research collaboration with the UQ School of Public Health.⁴⁸

Foremost among these problems, both for adults and children, is the intensive, emotional, often episodic, nature of mental health caring duties. These can make it extremely difficult for carers to work, or engage with education or training, or to do either activity on a full time or economically optimal basis. These structural issues are further exacerbated by inflexible or unsupportive workplace structures and job designs, and lack of assistance to help carers retrain, enter or re-enter the workforce. Specific needs also arise for carers, especially older carers,

⁴⁶ Ibid, 27.

⁴⁷ Diminic, et al, *Technical report*.

⁴⁸ Ibid.

when their care duties are no longer full time or reduce in intensity, leaving them with the need to update skills or engaged in pre-employment preparation, but little confidence to do so or knowledge of the services available to them.

We note a particularly concerning problem that is coming to light in the public domain, but which we contend has been happening but behind the scenes for some time, violence experienced by carers in the family home. Mind is aware of an increasing number of female family carers who are giving us accounts of their experience of violent assault from the person they care for when that person is unwell. There are few or no resources available to help women experiencing this kind of violence, and it generally remains silenced in service system interactions, in each of mental health, disability and family violence service settings. Nevertheless, this kind of family violence impacts on women's ability to engage with work, and because of the stigma and shame that surrounds mental illness, they may be reluctant or unable to draw on family violence leave provisions that their workplaces may offer. We believe that this is an emergent issue that needs exploration and urgent redress, to ensure that women's workplace engagement is not further impeded by family violence. (Of course, we recognise that this may be an experience that impacts male carers too, and should be addressed as such – it is just that our own experiences have related only to female carers to this point in time).

Another crucial problem is inadequate or inappropriate replacement care systems, a situation that has worsened as a result of the merging of services into NDIS. The NDIS has always had a complicated relationship to respite care. This is due to the lack of mental health related skills on the part of frontline NDIS staff, its focus on the participant for whom it may not be a priority for their carer to get respite, and the belief packages will provide so much support carers won't need to access formal respite services.⁴⁹ Before the introduction of the NDIS, mental health carers were able to access planned respite through a national program, Mental Health Respite: Carer Support (MHRCS), which provided short-term respite, amongst other supports. This program is currently in the process of being defunded and rolled into the NDIS. While the Federal government has provided some extremely limited transition funding (guaranteed only until November 2019) to ensure continuity of support for clients of the program, until they are deemed eligible or not for inclusion the NDIS, there is no detailed plan for how this will work and it is not clear whether this funding will be enough to meet existing needs.

Modelling undertaken by Mental Health Australia in 2017 identified that the MHRCS program alone assisted just over forty thousand carers in 2013-14. However, the modelling noted that the NDIS would provide respite services to approximately twenty thousand carers.⁵⁰ Not only is there a potentially significant unmet need in relation to respite services for those carers looking after individuals experiencing mental illness who qualify for inclusion into the NDIS; the

⁴⁹ Carers Australia, *Position Paper: NDIS Reasonable and Necessary Supports – the Case for Respite*, October 2018.

⁵⁰ Mental Health Australia, *Response to the Productivity Commission National Disability Insurance Scheme Cost Position Paper*, July 2017, 13-14.

situation is more serious for those outside the NDIS. This latter group will either be left without help or forced to rely on mainstream health services, increasing cost to the public purse.

Solution:

Improving the economic and social participation of mental health carers will only succeed through a multi stakeholder investment in reforming Australia's informal care economy, including changes to workplace culture, education, training, welfare, and superannuation policies. Mind would urge the Commission to examine the following suggestions, many of which are also made in the *Caring Fairly* submission to this Inquiry:

1. Measures to foster a greater understanding and acceptance of the economic contribution of unpaid mental health carers, and to better understand their support needs. Health professionals require education and training to understand the role, rights and responsibilities of carers in providing care. Tertiary and vocational education and training organisations and the Australian Health Professionals Registration Agency should ensure all health professional training programs include a requirement to understand the role of carers and volunteers in delivering high quality care in the community. A complementary effort also needs to be made within the NDIS. *The Guide to Working with Families and Carers of People with a Mental Illness* developed by a number of mental health organisations, including Mind, would be an excellent resource for improved governance of clinical mental health services that includes authentic carer representation.
2. In accordance with the recommendations of the *Caring Fairly* campaign and coalition, DSS and the Departments of Jobs and Small Business and Health, as well as the NMHC, union and business representatives, should collaborate on the creation of a National Framework for Carer Inclusive Workplaces. There should be a specific focus in the Framework on further research and the workplace needs and experiences of mental health carers, and carers with other types of episodic caring responsibilities. This investment should draw specific guidance and direction from the Work and Care Initiative spearheaded by Carers Australia,⁵¹ and new and emerging international initiatives from both government and civil society.⁵²
3. Investigate expanding the DSS' 'Carers and Work' program, to increase its reach and impact for mental health carers. The expanded program should sit within a cross-departmental portfolio taskforce jointly overseen by relevant departments.

⁵¹ See 'Work & Care: The Necessary Investment', Carers Australia, key information and documents accessible at: <http://www.carersaustralia.com.au/work-and-care/>

⁵² For an example of a multi-departmental government initiative, see the UK Government's June 2018 'Carers Action Plan 2018-2020', accessible at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/713781/carers-action-plan-2018-2020.pdf ; from the UK also, see Employers for Carers, led by Carers UK, accessible at <https://www.employersforcarers.org/>

4. Recommend government take steps to recognise, mitigate and overcome gender inequality among carers, including ways to examine and offset the long term, cumulative economic impacts of caring, particularly for women. As part of this, Mind would urge the Commission to consider reforms to the current system of retirement incomes and saving – including the Age pension and superannuation that is tied to either paid work or assets test limits.
5. Related to the issue of the shortfall in respite services, DSS, in cooperation with the NDIA, state and territory governments, and other stakeholders, undertake work to quantify the amount of unmet need in relation to respite services for mental health carers. These figures should specify how the shortfall will affect both those potentially in the scheme and left out of it, and a plan put in place to meet the shortfall.
6. In relation to the issue of violence against unpaid carers in the family, Mind would recommend that research be commissioned into the extent of the problem. Given the nature of experiences of violence and trauma, we recommend an approach where survivors are included in the research design and implementation. This research should then inform the development of education resources for unpaid carers and their employers, so that carers are aware of their ability to access appropriate family violence leave entitlements and employers react with sensitivity.

3.7 Housing and homelessness

The benefits of providing stable, long-term accommodation to those experiencing mental ill health are considerable. It provides a sense of stability and personal control that enables people to deal with other crises, and thus makes it more likely they will participate in employment, education and training, with further benefits to themselves, as well as to the economy and society.

Mind's service provision intersects with the issues of housing and homelessness for people with mental ill health in a number of ways:

- Supported residential rehabilitation programs across Victoria and Queensland, with a strong focus on early intervention.
- Supported accommodation for those with a mental and intellectual disability.
- The Haven Foundation, an innovative model of supporting independent long-term accommodation for people with a significant mental illness.
- Supported independent living in a mixture of self-contained units, stand-alone houses and boarding house style accommodation.
- The management of eleven Prevention and Recover Centre Services, or PARCs as they are known in Victoria, in cooperation with the area mental health services across the state. These offer 24/7 sub-acute short-term accommodation (28 days maximum) and clinical and psychosocial supports for people stepping down from a hospital stay or as a step up to avoid hospital admittance.

- A Community Recovery Program (CRP), in partnership with the Austin Hospital and Community Care Units in Toowoomba and Ipswich in partnership with Queensland Health. These provide 24-hour support and an accommodation stay of between six months to two years. This is a Step Up Step Down rehabilitation program for people with enduring and serious mental health issues who may be exiting a secure extended care service or forensic hospital, to assist them transitioning back to the community. It provides assistance with mental health issues, social and vocational life skills and other needs, including housing needs post-discharge. As these services are partnered with a health service, the staffing configuration includes psychiatrists, mental health nurses, and allied health staff, as well as Mind's community mental health nurses.

Problem:

As the Issues Paper notes, mental ill health is closely linked with housing problems and homelessness. Mind believes there are several dimensions to this issue, including the interrelationship between mental ill health, changes occurring in the housing market, shifting social and public housing policies, and how these relate to available support needs and possible new accommodation models. There are also issues regarding how the homelessness service system interfaces with mental health and other service systems. Further complicating the situation is the introduction of the NDIS.

The key problem, which the Commission's Issues Paper touches on, is the urgent need for discussion on what are the best accommodation and support models for people dealing with mental illness. As part of this we note the current framing of the 'problem' of how to house people with severe and persistent and/or complex mental illness is understood through the lens of housing-as-infrastructure. Mind would stress that the 'problem' dates back to de-institutionalisation and the insufficient attention and resourcing given to the question of where people should live whilst they are recovering and rehabilitating from serious illness, and what accommodation should be provided for those who need specific forms of housing support to lead productive lives in the community.

We argue that, for those who are most severely impacted by mental illness, including during periods of rehabilitation and recovery after extended bouts of illness, access to safe and appropriate housing can be understood through the lens of health. This offers a different way to view possible solutions.

Impact:

The maintenance of stable housing and the confidence that comes with the security of tenure and associated feelings of safety, are critical for recovery from mental ill health.

The relationship between mental ill health and homelessness is reflected in the most recent Australian Institute of Health and Welfare specialist homelessness services annual report. This

states that mental health services were the second highest services required for those who accessed homelessness support, after general health and medical services.⁵³ An estimated one third of the homeless have a severe mental illness.⁵⁴ Approximately 12-47% of children in homeless families experience mental health problems and it is estimated that 50-70% of homeless youths have some experience of mental illness.⁵⁵ To cite just one example, our service staff report seeing more older women in their fifties that may have rented or owned for a long time but now face significant housing insecurity. Some have had mental health issues in the past but have coped well, but the lack of security they now face is often enough to unravel what progress they may have made.

The issue of homelessness and mental health must be viewed within the context of well-documented changes to the Australian housing system, including the falling rate of home ownership and the growth of the private rental market. This is captured in an AHURI presentation to the NMHC, which details falling rates of home ownership and the extent of downward pressure this is exercising on the private rental market.⁵⁶ This is squeezing disadvantaged individuals and families, forcing them into more marginal and insecure forms of accommodation. Further exacerbating the problem is government policies that have seen declining public housing stock, traditionally viewed as an option for the cohort with issues such as mental ill health.

There has been a paucity of research on the more precise inter relationship and risk factors impacting housing instability and the onset of mental ill health and what is the best configuration of mental health and housing supports. The aforementioned Mind/AHURI study, '*Trajectories: the interplay between mental health and housing pathways*', to be published later in 2019, is designed to help fill this gap in knowledge. The study includes in-depth service mapping and analysis of data contained in the Melbourne Institute's Household, Income and Labour Dynamics in Australia (HILDA) Survey and Journey's Home longitudinal study of factors affecting housing stability. Mind is happy to pass the full study to the Commission after it is finalised. But it is useful to briefly summarise some of the key findings of the study that are pertinent to the inquiry.

The study found that poor mental health could lead to housing instability and homelessness. Deteriorating mental health also significantly increases the likelihood of subsequent forced moves. Interestingly, the diagnosis of a mental health condition can offer a protection from entering homelessness, because there is more likelihood it will ensure the individual is engaged

⁵³ Australian Institute of Health and Welfare, *Specialist Homelessness Services Annual Report 2017-2018*, Feb 2009, 16.

⁵⁴ Nicola Brackertz, Alex Wilkinson, Jim Davidson, 2018. *Housing, homelessness and mental health: towards systems change*, AHURI Research Paper, Australian Housing and Urban Research Institute Limited, Melbourne, available at https://www.ahuri.edu.au/_data/assets/pdf_file/0023/29381/Housing-homelessness-and-mental-health-towards-systems-change.pdf

⁵⁵ Ibid.

⁵⁶ AHURI, *Housing, Homeless and Mental Health*, presentation to cross-jurisdictional workshop: mental health, housing and homelessness, Mercure Treasury Gardens, Melbourne 28th March 2017

with the necessary supports to keep them housed. Indigenous Australians, those with longer histories of unemployment and lower levels of education, those born in non-English-speaking countries, and people opting out of responding to questions on violence, whom we hypothesise are much more likely to be currently experiencing particularly traumatic events, are less likely to access health services and, hence, diagnosis. This emphasises our earlier point about the need to not lose focus on those people who are most severely impacted by mental illness, and whom systems are least well-equipped to respond to in humane and effective ways.

Not surprisingly, housing stability allows people to focus on mental health treatment and rehabilitation while precarious housing and homelessness also makes it difficult for people to access treatments and supports for mental ill health. Perhaps the most pertinent finding of the Trajectories study, from the Inquiry's point of view, relates to what is the most suitable form of accommodation tenure for those dealing with mental ill health. Private home ownership has significant protective factors from housing instability and homelessness compared to private rental. Public housing has a similar protective effect on reducing risks of housing instability and homelessness to home ownership. Community housing, traditionally seen as a secure housing option, does not offer the same level of protection. According to the study this is because community-housing providers are more dependent on rent revenue and therefore less tolerant of rental arrears, and do not adequately monitor the mental health of their tenants, missing opportunities for early intervention before their tenancy gets to the crisis stage. Mind would also speculate the lack of protection offered by social housing is also related to downward pressure on the rental market. This has shifted the cohort accessing community housing to include many who would previously have found accommodation in private rental but who have effectively been priced out of that market.

The findings of the Mind/AHURI study are particularly important given the policy of state governments of transferring public stock to the community-housing sector. Another example of how government policy can potentially undercut sustainable housing outcomes for those with mental ill health is reforms in Victoria aimed at bringing public and social housing into a single register. This has a number of potential positives, including simplifying the process of applying for housing by ensuring individuals only need to apply once, to the central register for eligibility, rather than having to register with multiple providers. It also allows those providers that register with the single entry point to access a wider pool of tenants. But there are also significant potential problems. It makes the process of housing referral for clinical and community mental health services considerably less flexible. There are no KPIs to ensure that social housing providers source a diverse range of tenants and we are concerned providers may discriminate against certain groups, including those with current or past mental ill health, impacting their access to secure housing and reinforcing the problems they already experience in the private rental market. There is also the issue of how individuals, including those with mental ill health, find out about the central register and apply to be on it, especially if they are not engaged with support services.

The Mind/AHURI study also underlines problems with the broader service system, particularly the lack of integration and coordination between homelessness, housing and mental health services, the prevalence of which is also echoed by evidence from Mind staff. Examples include:

- Insecure housing means having to move between mental health catchment areas, and vice versa, which disrupts continuity of care.
- Homelessness workers not knowing how to work with local area mental health services, nor trained to see the signs of a client's mental deterioration or ill health until the situation is so far advanced that it is in the critical stages of impacting on their housing. Many clinical workers, in turn, will not accept the assessment of a housing worker.
- Further compounding this is the lack of knowledge and recognition of housing issues facing specific groups experiencing mental ill health. For example, on top of their mental ill health, there is evidence LGBTIQ clients experience discrimination at all stages of the housing cycle and homelessness services are not always queer friendly, especially to transgender clients. A 2017 university study noted evidence that housing/homelessness issues are heightened for LGBTIQ people.⁵⁷ They are at least twice as likely to have experienced homelessness as those who identify as heterosexual and face a range of specific structural factors associated with homelessness, including violence, harassment, and explicit and implicit forms of discrimination, arising from homophobia, biphobia and/or transphobia, on top of personal vulnerability arising from mental ill health.
- Discharge from clinical mental health services and institutions sometimes poses a significant risk for homelessness, a situation that may lead to further mental ill health. This is due to the lack of exit points into appropriate and stable housing and constraints within the health system to undertake appropriate discharge assessments, planning and follow up post-discharge. Staff in these facilities sometimes have little choice but to discharge clients into unsuitable accommodation such as rooming houses or a supported residential service. This can be re-traumatising for the individual concerned and/or expose them to drug use or other behaviour that may lead to relapse and see them back in hospital, at considerable cost to the public purse. Some PARC services will not accept individuals experiencing housing problems because they do not want to risk discharging into homelessness or being left with the responsibility to source accommodation. CRPs are reticent to take clients from social housing, because they can lose their accommodation while they are in care, resulting in the CRP staff being left with the job of finding them new accommodation.

The Trajectories study has also yielded data in relation to the, as yet, little understood need for Specialist Disability Accommodation (SDA) funding to be made available to those accessing the NDIS for psychosocial disability. SDA is funding for specialist capital supports for high need clients. This is perceived as only being suitable NDIS participants with a physical disability, and

⁵⁷ Ruth McNair, Cal Andrews, Sharon Parkinson, Deborah Dempsey, *LGBTQ Homelessness: Risks, Resilience and Access to Services in Victoria*, University of Melbourne Faculty of Medicine, dentistry and Health Sciences and Swinburne University of Technology, September 2017.

is currently not readily available for people with a psychosocial disability. Mind believes this highlights the lack of understanding about mental ill health and what supports people with a psychosocial disability need. Part of the data collected in the Trajectories project, includes interviews with individuals who have experienced poor mental health and housing instability. This has highlighted a number of housing needs for people with a psychosocial disability that are not met in their current housing and are not likely to be met by current social housing models in the future. These include:

- Soundproofing: difficulty controlling emotions means that those with mental ill health can be very loud when upset, which leads to complaints by neighbours and possible police involvement, which can further impact mental health. Additionally, hearing others, such as neighbours, arguing can be extremely distressing for those with a psychosocial disability and can trigger their own mental health issues.
- Women only properties for women with mental ill health who have experienced sexual violence and require an area where they feel safe with other women
- The provision of sensory rooms, which can be beneficial for those with psychosocial disability and contribute to well-being.
- Space for support networks to visit and stay.
- Modifications to enable people with a psychosocial disability to sleep better, including automatic blinds and the set-up of bedrooms.
- The provision of garden space, as the connection with nature can be important to recovery and can support physical and mental health.

Solution:

While expanding public housing is a politically unpalatable policy option for both major political parties, Mind would nonetheless stress the evidence from our AHURI collaboration that it is one of the most effective long term policy interventions for people dealing with mental ill-health.

Mind would also urge the Commission to examine strategies that would result in housing/homelessness and mental health services working better. Of particular importance is the need for more effective hospital and mental health institution discharge processes, as these can have a significant impact on the prospects for improved mental health and wellbeing and housing for people with a lived experience of mental illness.

In terms of specific housing models, Mind would encourage the Commission to examine models referred to as the 'Housing First' (HF) and the Haven Project.

Housing First:

HF is based on the notion that secure and appropriate housing is fundamental to recover from mental. Its core components include:

- Rapid access to secure housing with no readiness conditions

- Consumer choice
- Separation of housing and services
- Recovery as an ongoing process
- Community integration

HF originated in the US and has been applied successfully in Canada, where it was known as the At Home/*Chez Soi* Project.⁵⁸ A \$110 million HF trial operated from October 2009 to June 2013 in five Canadian cities, involving a randomised control trial of people with high needs, including severe mental ill health that compared HF to existed homelessness interventions. While both groups experienced improved outcomes, the results were particularly good for the HF cohort.

Aspects of the Canadian experience are hard to replicate in Australia, resulting in the adoption of what the Mind/AHURI study terms ‘low fidelity’ HF programs that align with the majority but not all of the HF principles. One specific contextual factor in Australia is the lack of affordable housing stock. There could also be potential disadvantages in the HF model for people on the public housing waiting list, as their priority listing is downgraded when they secure a property through a HF program, even though the accommodation may not be long term. A high level of service interconnectedness made the At Home/*Chez Soi* Project possible, including partnerships and buy in from not for profits, and government agencies and departments. The involvement of Ministry of Social Development in one site saw substantially reduced wait times for housing. There were also innovative partnerships with landlords and landlord associations.

Further complications arise from the implementation of the NDIS. State governments have responded to the NDIS roll out with different configurations of service integration and funding reallocation. In Victoria, funding for supported accommodation for those with mental ill health has been almost completely subsumed into the NDIS, with the result that it now takes two to three months to house an individual in one of Mind’s supported independent living units. It has to be part of the individual’s NDIS package. They have to be accessed as eligible, and the assessment has to be approved by the NDIA. While the NDIA has shown a preparedness to accept Mind’s recommendations regarding eligibility and, to their credit, is trying to streamline this process, it is nonetheless time consuming and bureaucratic. We are aware of people who need independent supported living but who have opted out or disengaged from the process, or for whom it has resulted in a relapse of health.

Despite these problems, Mind believes the HF concept should be considered by the Commission, both as a possible model and as a central organising framework to conceptualise how Australia might better facilitate access by those with mental ill health, to affordable, stable accommodation, and achieve greater service sector connectivity. As part of this, we would urge the Commission to examine how it can assist the process of engaging the private rental market with community mental health services in low fidelity HF programs. This includes programs

⁵⁸ *National Final Report: Cross-Site: At Home/Chez Soi Project*, Mental Health Commission of Canada, 2014.

where organisations head lease properties on the private rental market and provide support and financial assistance to tenants to ensure whatever problems they may experience they are dealt with before the tenancy is threatened, thus providing a safety net for real estate agents prepared to engaged with complex clients as renters.

The Haven Program:

The Haven Program provides housing for people who live with the impacts of mental ill health. The program recognises that secure, affordable housing is a critical aspect of recovery for many people. In order to maintain housing people with mental ill health often look for support and the opportunity to learn new skills, as well as working towards other goals that support their own personal recovery. The Haven program, therefore, includes support as part of its design.

The program is run by the Haven Foundation, a registered community housing provider, which merged with Mind in mid-2018 and is now a controlled entity within the organisation. Tenancy and property management services are run by Housing Choices Australia, and the 24/7 support services are provided by Mind, funded through the NDIS as supported independent living. In addition to long-term affordable and secure accommodation the service model includes:

- Extensive on site psychosocial support and recovery services.
- As part of supported independent living packages through the NDIS, clients receive services that are tailored specifically around their wishes and needs, and that support their recovery, with them taking the lead in deciding what supports they want. Each client develops a *My better life* plan where they state their own recovery goals; where these goals relate to clients accessing the broader community outside of their housing, Mind staff assist them to find possibilities which match them. Clients may also choose shared supports, including shared meal planning and cleaning, shared access to sleep over staff and shared group activities.

In the past, referral pathways have included Mind and other community mental health providers and clinical services. Assessment criteria include that the clients:

- Meet Housing Association asset and income limits.
- Be over 18 with no dependents.
- Be seriously affected by a severe mental illness and have an associated level of disability that cannot be met by alternative housing and support options.
- Want to live in an independent home environment and are assessed as having the potential to achieve a level of daily living skills and social function that can be successfully managed in a community setting.

The involvement of family members and carers, while not mandatory, is encouraged and highly valued. Family members and carers are also involved in the governance of the Haven Foundation.

The first Haven site in South Yarra has 14 units. With capital funding from the Victoria State Government, the model has subsequently been established in Frankston (18 units), and Geelong and Laverton (16 units each, to be completed in 2020), with expansion to Whittlesea in the pipeline. While the model does not suit everyone, we would recommend it to the Commission for serious consideration as an accommodation solution for those experiencing severe mental ill health. With the support of Mind, the Haven model has the ability to be up scaled quickly. It is also relatively cost effective compared to other models. One year of 24/7 supported accommodation for an individual at Haven's Frankston facility costs approximately \$100,000. This is compared to the annual cost per client of accommodation CCU (\$123,735), secure extended care unit (\$179,215) and hospital care (\$208,780).⁵⁹

Mind is happy to provide more details to the Commission about the Haven Project.

Lastly, Mind would encourage the Commission to examine the feasibility of introducing a psychosocial stream of SDA funding for high needs clients in the NDIS.

3.8 Income support

Problem:

The Issues Paper notes the overall growth of Disability Support Pension (DSP) recipients receiving a payment due to mental ill health, and speculates it results from issues such as existing income support recipients moving to DSP and broader structural changes to the economy. *Sick on the Job?* maintains there has been an increase in the share of mental disability support claims caused by mental illness in almost all member countries, especially by younger claimants. 'The reasons behind this increase are not fully understood,' it claims, but 'the trend is not the result of a higher prevalence of such disorders; and only partly is it due to the bigger labour market challenges these people are facing today.'⁶⁰ The OECD is particularly pre-occupied by the economic burden placed on member countries by increasing disability support claims and suggests at least one major reason for the growth is that many of the claimants have multiple co-morbid conditions and that there has been a shift over time towards making mental ill health the primary health condition underlining their reduced capacity to work. It also argues that, in addition to the lack of services to support claimants back into employment, the system is too easy and that they are granted full benefit immediately, and hence less likely to exit the system.

The Commission's thinking around income support also needs to be informed by a broader understanding of the social and economic barriers faced by those with a mental illness trying to enter or re-enter the workforce. While many DSP recipients with mental ill health want to work, the design configuration of the pension, combined with the episodic nature of mental ill

⁵⁹ Provided by the Haven Foundation on the basis of figures obtained for the 2012-2014 period.

⁶⁰ OECD, op cit, 205.

health, acts as a significant disincentive. This, in turn, relates to the low level of support provided by Newstart Allowance, the only alternative payment for people with a mental illness not on the DSP.

Mind also has significant concerns around the functioning of the Carer Payment, which deters carers from participating in education, training and workforce participation, which we will detail in this section.

Impact:

While some DSP recipients are simply unable to work due to the severity of their illness or medication regime, it is Mind's experience that the majority do want to work and, in fact, many are very skilled, having been engaged in the workforce, sometimes at a high level, before the onset of their illness. Research commissioned by Mind demonstrates that people living with significant mental ill health consistently rate the desire to work, in some form, as one of their highest priorities.⁶¹ A key motivation is increased financial independence, which is likely to lead to a wider choice in terms of leisure activities and living conditions. Workforce participation also provides social connection, empowerment, self-esteem and achievement. Many Mind clients are also sensitive of the negative social connotations of being a DSP recipient, including the perception it is essentially a form of warehousing people until they can get on the age pension, and would be happy to get off it.

A major disincentive is built into the design of the DSP. Recipients can work eight hours a week while on the DSP, after which a sliding scale kicks in leading to the pension being removed if they work more than 30 hours and once removed, it will take two years to be reinstated. The higher payment provided by the DSP has often provided recipients with mental ill health a measure of stability, in particularly around housing. Those seeking to enter the workforce take the risk that they will be able to retain employment, a move that may also need to take account factors such as the episodic nature of their condition. In the event of a reoccurrence of their mental ill health or some other instability in their life that means they cannot continue employment, their only option is to go on the much lower Newstart Allowance, which will result in a deterioration of their financial situation, with significant implications for them and, possibly, their carers, including the loss of accommodation. Mind staff are aware of examples of clients who have moved off the DSP into employment, been unable to maintain it and, as a result of being forced onto Newstart. They have ended up in substandard accommodation, where their mental health has deteriorated. The link between financial insecurity, mental ill health and housing insecurity is also reinforced by the analysis of data from the HILDA and Journeys Home surveys conducted by Mind/AHURI's Trajectories project on mental health and housing pathways, discussed in the last section.

The Commission's phrasing around income support and mental ill health reflects a wider disconnect between the dominant perception of people on Centrelink benefits and the reality of their lives. The process of getting onto the DSP is complex and it is our understanding that

⁶¹ Laura Hayes, et al, 2016.

only a small percentage of applications to go on it are successful. We are also aware of suggestions there is an unstated policy on the part of the Commonwealth government, enforced by Centrelink, to reduce the number of DSP recipients. This is certainly one interpretation of the graph on page 20 of the Issues Paper which shows a decline in the share of working age population receiving DSP for mental illness, due to what the Paper describes as a ‘tightening of the mechanism for assessing work capacity introduced in 2012’. We maintain any short-term budget benefit that may accrue from further restricting DSP access or forcing those on it into employment they cannot sustain, would be lost by longer-term outlays on higher service system expenditure, as people are forced into a greater engagement with services systems, such as homelessness, to survive.

The Commission must start from the assumption most DSP recipients with mental ill health want to work but face a number of overt and not so overt barriers to employment. This may begin with the fact that they are scared and doubt themselves and their abilities, and build in intensity from there. Individuals may be socially isolated, which in turn can impact on their presentation and physical health, need workplace experience and skills training, and/or lack the financial resources necessary to buy work clothes or afford transport. A recent Melbourne University study of financial hardship and levels of indebtedness, highlighted that over 22% of respondents claimed they were experiencing mental ill health in the 12 months before their debt problems began.⁶² Relying on a Centrelink income was the second most common experience. Mind staff report that certain groups, such as LGBTIQ people with mental ill health, face additional barriers in the job market, including discrimination in selection processes and on the job by managers, clients and co-workers. This is supported by the findings of a 2015 New South Wales Council of Social Services report into poverty and disadvantage faced by LGBTIQ people.⁶³

A related issue applies to the Carer Payment. This is a critical income support payment for Australia’s unpaid carers. However, the criteria for qualification for Carer Payment restricts opportunities for carers to participate in paid work and education, through both the income and assets test, and by inflexibly restricting a carer’s participation in work or education to 25 hours, including travel time (the ‘25 hour rule’). The ‘25 hour rule’ is not prescribed by legislation but is provided for by Department of Social Services’ policy directions in the *Guide to Social Security*.

The ‘25 hour rule’ can disadvantage carers seeking to engage in paid employment or education. It creates particular difficulties when carers need to transition in and out of work as the need for care intensifies or reduces. It can be especially problematic for mental health carers, and other carers, where care is unpredictable and episodic.

⁶² Evgenia Bourova, Ian Ramsay, Paul Ali, ‘What 1,100 Australians told us about the experience of living with debt they can’t pay,’ *The Conversation*, February 26, 2019, <https://theconversation.com/what-1-100-australians-told-us-about-the-experience-of-living-with-debt-they-cant-repay-105296>

⁶³ New South Wales Council of Social Services, *Beyond the Myth of ‘pink privilege’: Poverty, disadvantage and LGBTI people in NSW*, 2015

The rule creates particular challenges for young carers participating in primary, secondary or tertiary education when they could undertake part-time work to help support their families. It creates challenges for anyone undertaking education or training for any reason, including returning to work. It can create a disincentive for carers in education or training to engage with further study or employment, forcing them to make important life choices based on arbitrary factors such as the number of course contact hours or location of the institution. Alternatively, they can feel pressured to conceal study or employment from Centrelink to circumvent the rules⁶⁴.

Solution:

In relation to the DSP, the Commission should examine:

- Changes to Centrelink process to simplify the assessment process.
- Recommend introducing flexibility so that individuals with mental ill health who move from the Pension to employment and find, that for whatever reason, they are not able to sustain it, are able to move back onto it, rather than the inferior level of Newstart Allowance.

In relation to the Carer Payment, the Commission should recommend that the government review the 25-hour rule. As part of the review, government should examine reports from carers that reporting 25 hours or more of work and travel can lead to Carer Payment being immediately cancelled by Centrelink⁶⁵.

As part of this review, more flexible approaches to measuring the hours of care provided could be examined, considering approaches to supporting carers with episodic or unpredictable caring responsibilities. This should include exploring the possibilities for unpaid carers to 'bank' paid working hours, and/or report, offset and aggregate paid working hours over a longer period than a fortnight.

3.9 Psychosocial disability support services in the context of service gaps in the NDIS

Problem:

The Commission is correct to discuss the availability of psychosocial services in the context of income support and employment, as these services have proven to help people experiencing mental health make gains in the area of social and economic participation, particularly if they are offered early. The focus on the cohort with the highest levels of need in relation to participation and productivity is also important because they incur the greatest costs to the public purse and, consequently, with the right arrangements, are where the greatest gains can be made (notwithstanding the moral arguments for ensuring the best support to the most

⁶⁴ See: Submission by Behavioural Insights Team Australia into Try, Test and Learn Fund, December 2016, accessible at: https://engage.dss.gov.au/ttl_fund_dec16-submissions/sub-id-4881-carer-payment-25-hour-rule-behavioural-insights-team-australia/

⁶⁵ Carers Australia, 2019-20 Federal Budget Submission, January 2019, 8.

marginalized and excluded citizens). However, the subject of psychosocial services cuts across other areas being examined by the Commission.

Mind supports the Commission's position not to re-prosecute what is already the subject of inquiry and/or remedial action elsewhere regarding NDIS support to people with psychosocial disability, unless there are significant new issues or problems identified by inquiry participants that are not adequately attended through existing initiatives. We also note efforts currently being undertaken within the NDIA to improve the Scheme's functioning for participants with psychosocial disability. That said, we recommend that the Commission consider the role played by the NDIS in a system of supports for people with moderate, high, very high and complex needs, as outlined in the NMHC 2014 report.⁶⁶ When viewed systemically, a number of concerns arise that are not visible when the focus of inquiry is the NDIS itself. We argue that a systems view is particularly helpful in revealing and understanding the gaps that are emerging as a consequence of (although not specifically to be addressed by) implementation of the NDIS. These relate to very serious levels of unmet demand for support.

Impact:

This submission has already discussed issues in relation to the definition and importance of psychosocial issues, including the findings of previously cited paper by Harvey et al that were developed on analysis of data collected for the 2010 survey of people with high impact psychiatric illness.⁶⁷ This paper precedes the wide-scale roll out of the NDIS, and therefore reveals important conditions that were available prior to roll out, and the assumptions about what could/should be addressed by the new Scheme. The authors' note there is a lack of clarity regarding the characteristics of individuals who were receiving NGO services at the time of the NDIS roll-out, as well as a lack of clarity on the respective contributions of clinical mental health services and those provided by NGOs. Mind argues that, based on our current service data, this lack of clarity has been carried forward into NDIS rollout and consequent service configuration.

To assist current Partners in Recovery (PiR), Personal Helpers and Mentors Scheme (PHaMS) and Day-to-day Living (D2DL) clients prepare their NDIS application, we undertake a World Health Organisation Disability Assessment Scale (WHODAS) assessment to gauge their level of functionality and likely support needs. For this submission, we reviewed the records of 26 people who had received a WHODAS score through this process. Scores ranged between 49 (out of a possible 144) and 118, with lower scores indicating higher functionality. Our data does not enable us to tell whether each of the 26 were accepted into the NDIS, and noting that package size is also related to the goals that participants set for themselves. Despite these limitations, we note a lack of consistency between the WHODAS scores and ultimate package size for those who have plans with Mind. We contend that a more open and transparent

⁶⁶ National Mental Health Commission, *Contributing live, thriving communities: Report of the National Review of Mental Health Programmes and Services*, Australian Government, 2014.

⁶⁷ Harvey, et al, op cit, 2016.

approach to assessment for eligibility, and assessment for package size would enable better targeting of resources, with an ultimate impact on productivity.

To understand how this situation came about, we return to the NMHC 2014 report, and draw the Commission's attention to the description of the population distribution of mental illness and the population need for support.⁶⁸ We note that the population with serious and persistent mental illness (SPMI) plus the population with SPMI *and* complex multi-agency needs comprises 690,000 people in total (based on 2014 figures).⁶⁹ This equates to the cohorts with high/very high needs where supports required include:

- Personalized packages of care (health and social)
- Care co-ordination
- Assistance to maintain connection with family and friends
- Housing support
- Employment support
- Income support

Outside of the clinical treatments, the supports need to be delivered by a workforce with capabilities in providing recovery-oriented psychosocial and social supports.

Mind notes that the support need for these cohorts is consistent with the description of support needs for people in Tier Three in the Productivity Commission's original 2011 conceptualization of the NDIS, and yet the modelling for the Scheme in the same report only identified 57,000 people with psychosocial disability in the Tier Three cohort. We can only assume that this seeming disparity between population modelling and support provision accommodated in the Scheme was that there would be substantial provision of psychosocial support, as rehabilitation, for people outside of the NDIS, funded through state/territory governments and delivered through PHNs. We note that currently this has not happened. NDIS has consumed a great deal of funding that previously provided supports to a far wider range of people with psychosocial disability.

This is concerning for two reasons.

Firstly, as already noted in section 3.6, the Commission's 2011 inquiry into disability support expressly supported the argument that the Scheme would contribute to higher productivity due to unpaid family carers of people with significant psychosocial disability being provided with replacement care, enabling them to engage more with the labour market. However, the introduction of the NDIS appears to have inadvertently reduced support to those with high and very high needs and their family and carers, with impacts for the latter's health and engagement with education, training and employment (although as the UQ report notes,

⁶⁸ National Mental Health Commission, *op cit*, 5.

⁶⁹ *Ibid*, 11.

whether or not female carers get formal respite support does not impact on their employment prospects).⁷⁰

The second major concern relates to the need for a deliberately designed, evidence-based service system response for psychosocial rehabilitation that operates on the principle of intervening as early as possible in episode and in life, comprehensively, and with a co-ordinated and integrated package of supports. Harvey et al found that amongst the group of people they studied with significant levels of disability and complex needs there was a group with limited socialising who were less likely to be in receipt of NGO services in addition to those provided by clinical mental health services. This suggests the need for improved targeting of supports to ensure they get to those who need them most.

Mind is particularly concerned about this finding when considered alongside NDIA data suggesting that a large number of people who are being found to be eligible on the basis of psychosocial disability do not currently access services. We do not believe that this cohort is entirely consistent with the sub-group in Harvey et al's study, who, in our experience continue to miss out because service systems are not good at reaching and engaging with them effectively. We are concerned that this indicates one or both of two things: a cohort of people with psychosocial disability unknown to service systems, and/or poor targeting (associated with a lack of effective assertive outreach).

Solution:

Mind reiterates the recommendation it made in relation to section 3.6 of this submission, relating to the short fall in respite support, that DSS, in cooperation with the NDIA, state and territory governments, and other stakeholders, undertake work to quantify the amount of unmet need in relation to respite services for mental health carers. These figures should specify how the shortfall will affect both those potentially in the scheme and left out of it, and a plan put in place to meet the shortfall.

Mind also suggests the Commission investigate the following:

1. Services gaps in relation to the provision of psychosocial rehabilitation services for both NDIS clients and those who do not qualify for the disability insurance system.
2. The introduction of a nationally consistent, standardised approach to assessment of psychosocial support needs, delivered in conjunction with specialist clinical services. This should be part of a tiered response that would give people access to psychosocial rehabilitation services (with an early intervention focus) first for a period of up to five years, after which time those with ongoing support needs would be automatically eligible for the NDIS.

⁷⁰ Diminic et al, *Technical Report*, 18

3. In relation to the situation for family carers, we also suggest that DSS undertake a full review of the Integrated Carer Support System after a 24-month period, to ensure that it is delivering to intended targets, and to assess any partially or unmet need.

3.10 Justice

Problem:

The Commission's focus in this area is skewed to the forensic end of the intersection between justice and mental ill health: individuals with complex problems, often from significantly socio economically disadvantaged backgrounds, who have experienced repeated contact with the justice system, occasionally resulting in incarceration. Mind agrees there are serious issues in terms of the inadequate resources to adequately deal with mental ill health in the prison system and the problems of assisting these people to transition back to society. However, specific data on this issue sits outside the scope of our expertise.

In our contribution to this component of the Issues Paper, however, Mind wants to suggest a reframing of the discussion, and encourage the Commission to examine the economic and productivity costs of systemic unmet legal need that exists in a variety of settings by people living with mental ill health.

In particular, we want to discuss the work Mind is doing in the area of health-justice partnerships. This is a concept that originated in the US in the 1990s, where they continue to be referred to as 'medico-legal partnerships'. These initiatives, which have gained significant traction in Australia since 2012, involve taking legal services into a specialist medical or health setting, and in doing so bringing healthcare and legal professionals together to address the social determinants of health and their legal interface, and overcome the disconnect that often occurs between the health and legal/judicial systems.

Impact:

There is a significant unmet demand for legal services on the part of people with poor mental health. Evidence from the UK, mainly in the area of welfare rights, shows that mental ill health both follows on from and increases vulnerability to legal problems.⁷¹ People with mental ill health can experience fear of disclosure, real and perceived communication problems and other capability issues. These can make even relatively simple legal problems appear overwhelming, while agoraphobia or panic attacks can contribute to a journey to a legal service or advice centre being difficult. The key finding focused on the importance of integrating legal services into mental illness and other support services. Local research by the Law and Justice Foundation confirms the nexus between disability and illness, including mental illness, and the

⁷¹ Linda Gyorki, *Breaking down the silos: Overcoming the Practical and Ethical Barriers of Integrating Legal Assistance into a Healthcare Setting*, Churchill Fellowship and Inner Melbourne Community Legal, 2014, 28.

increased experience of legal problems. ‘Not only do people with illness/disability have high legal and health needs, but it is well documented that they can face a range of obstacles in accessing services.’⁷² In particular, people with a mental illness experience both individual and systemic barriers to accessing legal advice and their sense of the problem being overwhelming can result in them avoiding addressing the issue, leading it to increasing in seriousness and consequences for the individual concerned. Research has also noted the importance of providing legal services to young people who are experiencing mental ill health as they often experience a range of interrelated personal, practical, emotional, health, social welfare, and legal problems simultaneously.⁷³

Solution:

Recognising the patterns of structural inequality in terms of access to legal advice experienced by people with mental ill health, in 2017, Mind began a small scale health/justice partnership with a community legal centre in the western suburbs of Melbourne, WEstJustice. This involved embedding a WEstJustice lawyer in one of Mind’s community services in the Western suburbs, two days a week, to provide general advice and assistance, build trust, and create a space where conversations could be held around legal issues. To date, a total of 38 clients have been assisted and advised on multiple legal matters over a period of 22 months, with an average of three issues per client, with some clients referred to other services. There was a striking degree of commonality regarding the issues dealt with over this period:

- Infringements/fines.
- Consumer debt, mainly credit card debt and people being upsold on products when they have been on medication or, in one case, put into a ‘lock in’ contract when they were in a psychiatric ward.
- Family violence.
- Superannuation/insurance, including enforcing disability insurance components of superannuation policies. This has secured over \$1.5 million in payouts for three clients.
- Social service inquiries, mainly advocacy relating to people being transferred from DSP to Newstart, and assistance with how to word applications to go on the DSP.
- Matters to do with power of attorney and wills for carers with mentally ill children.

With funding from the Victorian Legal Services Board, over the next two and a half years Mind is working to expand to take in partnerships between Mind’s frontline community mental health services and at least six community legal services. Mind services will be the contact point, and the scope of services covered will be focused, initially, on the six issues identified above. Mind believes that this is an exciting and innovative model that will deliver pragmatic legal services to a community that has been structurally disadvantaged in accessing it. In addition to providing legal advice and representation to individuals experiencing mental ill health, the model aims to collect data from case work to develop an evidence based platform to develop

⁷² Ibid, 29.

⁷³ Ibid, 30.

pragmatic policy solutions to improve health, social and economic outcomes for the target community. It will also provide training to Mind staff on issues relating to access to justice and the law. The desired end point is to develop a best practice model for how to deliver legal services to a hard to reach community and to scale it up beyond Mind and, if possible, to establish a separate legal mental health service.

We bring to the Commission's intention that an independent evaluation of this model, conducted by researchers from La Trobe University, is underway.

Mind would argue that there is compelling evidence that intervening early in the life cycle of many legal problems experienced by people with mental ill health can have significant benefits. This includes:

- Integrating legal advice, information and representation into a model of recovery oriented care, with improved legal outcomes for individuals, often accompanied by beneficial impacts for their mental health.
- Diverting individuals from a deeper engagement from the justice system.
- Financial savings in terms of reduced interaction with legal and other service systems, in terms of preventing indebtedness, and homelessness. Mind is in the process of building a comprehensive database of these savings.

Mind is happy to provide more information on its model of health-legal partnerships, should the Commission require it.

3.11 Education, training and government support to find and maintain a job

The issues involved in this area of the Commission's Inquiry are complex and cross cutting, as evidenced from input already provided by Mind in relation to:

- The social, economic barriers and health barriers to employment faced by those with mental ill health
- The proven effectiveness of psychosocial service supports, especially if they offered early, to enable people suffering from mental ill health to make gains, including in the area of employment.
- How aspects of Australia's system of income support deter those with mental ill health and their carers from accessing education and employment.
- The importance of improving education and employment outcomes for mental health carers.
- A greater role for people with lived experience in the mental health workforce.

In addition to these issues Mind would make the following very brief comments.

Problem:

As we have already noted, employment is a major priority for Mind's clients, both for its social and economic benefits and as a vital marker of recovery. Rosenberg notes that while data on mental health and employment is thin, figures supplied by the Productivity Commission as part of their Report on Government Services, reveals that around 62% of people with mental ill-health are unemployed, a figure which is about the same as a decade earlier and considerably lower than among the population without mental illness.⁷⁴ These figures point to problems in government supports in the area of education, training and job placement for people with mental ill health.

Mind would also reiterate the issues faced by carers in terms of participation in education, training and the labour market.

Impact:

The need to deliver improved employment and was a key rational of NDIS as it was originally conceived in the 2011 Productivity Commission report into disability care and support. The importance of supported employment services and specialist transfer to work programs were mentioned numerous times as a key part of the support that would be provided by NDIS. In reality very few NDIS participants that Mind works with have employment support in their plans, even when they could be working or want to work.

Rosenberg and Hickie note that 75% of mental ill health manifests before the age of 25.⁷⁵ This reinforces the importance of early and effective psychosocial interventions, as has been stressed throughout this submission, so as to avoid not only a lifetime of mental ill health but to ongoing social disadvantage, for the young people concerned.

While Mind is not an employment agency, we have done some work in the training and employment space, as part of interventions to improve outcomes for clients in this area. Our experience from this has revealed several problems with Commonwealth's system of employment support:

- Job providers lack understanding of the barriers to employment faced by people with mental ill health. This is reinforced by their KPIs, which focus on payment when they get someone a job, regardless of whether it is an appropriate or sustainable outcome and even if the person who they put in the job's mental health deteriorates.
- Bureaucratic and rigorous Centrelink processes, which can be confronting to someone with mental ill health. Rapid job placement is very important otherwise people with mental ill health can quickly lose confidence and drop out of whatever program is in place.
- Disincentives built in the configuration of the DSP, detailed in section 3.9.

⁷⁴ Rosenberg, op cit.

⁷⁵ Rosenberg and Hickie, op cit, 37.

On the other side of the problem, community mental health staff often lack knowledge around how to effectively deal with Centrelink and job providers, including the function of employment services and different service streams available.

Foremost among the barriers to improving the participation of carers in education, training and the labour market is the intensive and episodic nature of caring duties, which make it extremely difficult for carers to work full time or even at all. The 2017 UQ report noted unexpected fluctuations in support needs, together with an average of 60 hours per week 'on call' for primary mental health carers, which had a major impact on their ability to take up and maintain stable and predictable employment or engage in education and training.⁷⁶ This is further exacerbated by inflexible or unsupportive workplace structures and job designs, and lack of assistance to help carers retrain, enter or re-enter the workforce. Specific needs also arise for carers, especially older carers, when their care duties are no longer full time or reduce in intensity, leaving them with the need to update skills or engaged in pre-employment preparation, but little confidence to do so or knowledge of the services available to them. Another crucial problem is inadequate or inappropriate replacement care systems. As noted, this has got worse as a result of the merging of services into NDIS. We would particular note the impacts on female carers, previous discussed, and the young.

An emerging body of evidence points to the fact that all young carers tend to leave school earlier and are less likely to be in the labour market.⁷⁷ The 2018 UQ research illustrates patterns evident in government data, indicating that almost 13% of children with a mental health caring responsibility aged 5 to 14 are not attending school⁷⁸. This compares to 100% school attendance for other categories of children with caring responsibilities in this age group, and just over 95% school attendance for all other children. There are major long-term individual and societal impacts for the cohort of children with a mental health caring responsibility not attending school.

Solution:

Mind suggests the Commission examine how to enhance connections between, mental health services, Centrelink and job providers.

We would also suggest investigating the feasibility of mental health specific career counselling services that have expertise in this area, including using people with lived experience of mental ill health.

Mind has already made suggestions as to how improve carer's participation in work and training. Echoing the Caring Fairly submission, we would particularly like to take the opportunity to recommend the following issues in relation to carers:

⁷⁶ Diminic, et al, 2017, 33.

⁷⁷ Department of Social Services, *Young Carers Research Project: Final Report*, September 2002.

⁷⁸ Diminic et al, 2018, p19

1. The Commission examine approaches to supporting carers with episodic and unpredictable caring responsibilities. This includes the suggestion made by Caring Fairly in their submission of the possibilities of unpaid carers to 'bank' paid working hours, and/or report, offset and aggregate paid working hours over a substantially longer period of time.
2. In terms of young carers, the Federal Department of Education and Training, together with state and territory education departments, DSS, The Australian Bureau of Statistics and the Australian Institute of Family Studies should design a national strategy to more holistically identify and assist children with caring responsibilities in Australia. This could include:
 - A national framework for schools and teachers to better identify those students that provide care to a relative with mental ill health and provide supports to prevent disengagement or poor outcomes. Similar policies should be developed in the VET and university sector.
 - Ensuring that all Australian datasets, especially longitudinal studies, routinely collect information about the condition of people being cared for to allow more detailed analysis and comparisons between carers of different conditions.

4. Framework to enhance mental health and improve participation and workplace contribution

Whilst the 2014 NMHC report proposes a population based architecture for responding to mental health needs from whole of population to the cohort with high-very high needs, our current policies, frameworks and reporting arrangements are inadequate to respond to substantially different situations that constitute mental health and ill health in Australia.

We recommend an integrated, three-tiered structure, where each tier responds to a difficult kind of mental health need.

- Firstly, investment in preventative measures aimed at whole of population, delivered to families and communities to build resilience and encourage people to help themselves and each other.
- Secondly, wide-scale system responses for people with low to moderate needs, largely accessed through Medicare and delivered with MBS funding, including psychological therapies. In most circumstances, this cohort will not require a specialist mental health response, and can be dealt with via their GPs and associated practitioners. Some access to social support may be required for some people in this group, but is may be accessed through existing social and community services, without specialised psychosocial intervention.
- Thirdly, we support a system of specialised treatment and care, delivered through models that integrate and co-ordinate clinical, psychosocial and social supports for people with the most serious and persistent forms of mental ill health.

In each case, identification, intervention and treatment should be available as early as possible – early in life, and/or early in any given episode of illness. We concur with the principle of ‘investing to save’, and that greater mental health spend to promote the mental health and wellbeing of families, young children and adolescents will pay off in the longer run. However, this should not occur at the expense of adults of working age, and older adults, who also need early intervention and investment to prevent escalating costs of unaddressed mental ill health.

4. 1 Co-ordination and integration

In order to address the situation outlined in this response as it relates to people with severe and persistent and/or complex mental illness, a clearer conceptualization of mental health need is required, with distinctions and interrelationships between clinical mental health treatments, rehabilitation supports, and disability supports. When insufficient support is provided, or is not timely, the functional impact of mental illness is likely to increase.

We refer back to the system design features outlines on page 16 of this response, and the elements of a comprehensive, holistic approach to the mental health needs of people at the high and very high end of the population on pages 17-18.

Along with these design elements, we suggest that what is then required is a tiered response that would give people access to psychosocial rehabilitation services (with an early intervention focus) first for a period of up to five years. Those with ongoing support needs beyond this time would then be automatically eligible for the NDIS. This is an inversion of the current arrangements, where people are being asked (or required in some jurisdictions) to apply for the NDIS first, and can only be considered for eligibility into other programs (for instance, those currently being commissioned through PHNs) if they are deemed to be ineligible for the NDIS.

Central to a more co-ordinated, integrated and targeted system of care is a nationally consistent, standardized approach to assessment, available to anyone whose needs cannot be met through the MBS system alone. Consistent, standardised assessment would comprise:

- An assessment service available to anyone with mental health issues who is also showing signs of reduced functional capacity ('red flag' or marker that a greater level and different type of assistance may be required). This would include a no 'wrong door' access to the assessment service.
- The use of standardised assessment tools, implemented by multidisciplinary teams (rather like the comprehensive needs assessments undertaken in the UK, as part of the National Health Service response to frail aged people).
- Holistic assessment undertaken over time, in the individual's regular living context
- The collection of standardised outcomes measures and satisfaction data.
- The development of a holistic care plan for an individual that the full range of providers then contribute to, across the medical, psychosocial, social and community services sectors. The plan should take full account of their living situation, and family support needs where relevant.

The single national process would ensure that people were directed to the appropriate funded program (for instance, psychosocial rehabilitation outside of the NDIS, before being tested for NDIS eligibility). This would ensure more effective targeting of resources, with less waste and duplication.

To ensure co-ordination at the individual and family level, each person/family accessing psychosocial and social supports for their mental health should be assigned a trusted worker, who acts as a point of connection with services:

- Clinical mental health services, including inpatient services.
- Psychosocial rehabilitation.
- Social and community services (housing, education, employment, children, youth and family support).
- Disability services delivered through NDIS (if required).
- Physical health services.

The trusted worker role should combine elements of case management and facilitation, system navigation and support. Workers with a range of experience and qualifications, including peer

workers, could undertake this role. In some cases, a team of workers might provide co-ordination supports.

We suggest that the following gaps exist, or are emerging for people with high, very high and complex needs, regardless of whether they are eligible or ineligible for NDIS:

- Services for family carers of people with high impact illness, particularly flexible respite.
- Assertive outreach for people who may find it hard to engage with services, particularly those who live in marginal accommodation and/or are homeless
- Supported housing for people recovering from severe or prolonged episode/s of illness.
- Access to psychological therapies, on a weekly basis.
- The capability in existing services, such as trauma informed care.

We argue for a nationally identifiable service system for psychosocial rehabilitation that would meet these needs:

- Delivery of 'rehabilitation' services (integrated response including clinical and social supports, housing, employment and income support, support to retain/regain connection to family and friends and care co-ordination (for those who need it).
- As part of the above, access to psychological therapies through an expansion of the Better Access scheme, recognizing that people with high, very high and complex support needs require ongoing psychological support as part of maintaining functioning and wellbeing. We suggest that people need up to 52 sessions per year, under the current arrangements for Better Access. This should be made available to people regardless of whether they are NDIS recipients or not.

In terms of specific questions raised by the Commission in relation to psychosocial disability and social services, coordinating clinical and non-clinical mental health services rely on a conceptualization of mental health support, particularly those with moderate, high, very high and complex needs, that understands the lived experience as one that includes symptoms of illness or disorder that can be addressed clinically and experiences of difficulty in everyday life and community tasks. This includes internal experiences of illness, for instance lack of motivation, difficulty with processing information, communicating compounded by stigma and discrimination, and the fear of stigma and discrimination. In practical terms, better integration requires a mixture of services that have been designed as models that integrate clinical and psychosocial supports.

4.2 Funding arrangements

Mind has already addressed a number of issues related to funding arrangements in the course of our response. However, we would take the opportunity to re-emphasise some of our arguments and make additional points.

As we have emphasised, the current mental health service model remains focused on clinical/biomedical interventions that address people's medical needs, mainly in a hospital setting, rather than services that provide the practical emotion and social supports people with mental ill health need to gain/regain a productive and meaningful life. This focus has skewed funding away from organisations that provide social and psychosocial supports in non-medical settings, a trend exacerbated by the NDIS. The expense incurred in ensuring this current service delivery framework remains sustainable was set out in a 2015 report co-authored by ReachOut Australia and EY.⁷⁹ This stated that even a modest increase in the proportion of the populace seeking mental health services, which is estimated to occur over the next 15 years as the population grows, will require a substantially increase in public investments in service provision and workforce development.

Evidence of the benefits of taking a different approach, one in which more funding is directed to community mental health providers who deliver the bulk of social and psychosocial services, is set out in the KPMG modelling for the NMHC mentioned at the beginning of this submission.⁸⁰ KPMG modelled a number of what it described as more optimal service system models, more focused on 'upstream service provision', i.e., one that placed greater emphasis on primary and community care and interventions aimed at improved outcomes in areas such as employment, housing, welfare and justice. It stated 'that upstream service provision delivers better outcomes at lower cost over time than those [systems] with a higher focus on downstream acute services.'⁸¹ It also reported lower costs associated with better service system responses related to housing and justice.

Mind would also briefly restate its earlier arguments around the problems with current funding arrangements: short term contracts, uncertainty around when tenders will be decided, short notice on contract end dates, and commissioning bodies that don't have a good understanding of the systems they are commissioning into. These points directly respond to the specific question posed by the Commission on current arrangements for commissioning and funding mental health services through government departments and PHNs. Mind would recommend that Commission examine longer contractual time frames, at least three to five years. We also reemphasise the point we made in section 3.4 and encourage the Commission to recommend government funding that includes the full cost of providing support to someone with mental ill health, including the time and emotional labour involved in servicing relationships with clients and carers and liaison between workers, different organisations and service systems.

⁷⁹ Aran Hosie, Gillian Vogl, Joanna Carden, John Hoddinott, Simon Lim, *A Way Forward: Equipping Australia's Mental Health System for the Next Generation*, ReachOut Australia and EY, 2015.

⁸⁰ KPMG, op sit.

⁸¹ Ibid, 12.

4.3 Measurement and reporting of outcomes

This is another area touched on earlier in this submission. We note a great deal of the focus in relation to current data collection concerns the acute end of service provision, a point made by Rosenberg and Hickie, and reiterated by KPMG modelling commissioned by the NMHC. The Commission could play an important role in this regard, by investigating funding for innovative research projects to overcome the lack of detailed research on the outcomes delivered by community mental health services. As part of this, funding provided to community mental health providers needs to include sufficient administrative costs to collect, analyse and report on outcomes data.

A system that is more clearly designed, as we recommended in our response to the question of coordination in section 4.1, would also assist in this area. Monitoring and reporting need to be tied to a clear strategy that distinguishes between whole of population mental health, the needs of the majority who become unwell, and the needs of those with high and very high levels of need.

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1300 286 463

Carer Helpline

1300 554 660

mindaustralia.org.au

mindconnect@mindaustralia.org.au



Mind Central Office | 86-92 Mount Street
PO Box 592 | Heidelberg VIC 3084

Mind Australia Limited ABN 22 005 063 589