cohealth

Submission to Productivity Commission inquiry:

The Social and Economic Benefits of Improving Mental Health

April 2019

About cohealth

cohealth is one of Victoria's largest community health services, operating across 10 local government areas in Victoria. Our mission is to improve health and wellbeing for all, and to tackle inequality and inequity in partnership with people and their communities.

A primary health service, cohealth provides integrated medical, dental, allied health, mental health and community support services. 850 staff over 37 sites deliver programs promoting community health and wellbeing and involving communities in understanding needs and developing responses. Our service delivery model prioritises people who experience social disadvantage and are consequently marginalised from mainstream health and other services – such as people who are experiencing homelessness or mental illness, Aboriginal and Torres Strait Islanders, refugees and asylum seekers, people who use alcohol and other drugs, recently released prisoners and LGBTIQ communities.

cohealth has had lengthy experience providing responses to people living with mental ill health. Our work is person centred and based on a recovery framework and strength-based approach. Our services to people experiencing mental health issues currently include mental health nursing, individual support, outreach services, mentoring, residential programs, homeless outreach, and complex care coordination. We have a particular focus on providing mental health support that takes account of the social determinants of mental health to ensure support is integrated with physical health care and social support programs, such as housing, employment and family support, and those aimed at reducing social isolation. Recognising that people with multiple and complex needs face greater barriers to accessing services and supports, along with health and social disadvantage, cohealth prioritises working with these people to maximise their mental and physical health and wellbeing outcomes. In response to the significant unmet needs of people with mental illness who are completing Corrections Orders we have also established a Forensic Mental Health Service as part of the overall Community Health Service offering.

cohealth also recognises that health – including mental health - is affected by many factors including social inclusion and participation, education, housing, employment, and access to fresh food, and we are committed to addressing these underlying causes of health inequality. To this end, we work directly with people and in the community to design our services, and deliver advocacy, health promotion and education activities to improve health and connectedness.

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Executive summary

cohealth welcomes the opportunity to provide a submission to the Productivity Commission inquiry into *The Social and Economic Benefits of Improving Mental Health*. cohealth provides a range of services for people experiencing serious mental illness, including residential accommodation, community outreach, mental health nursing, mentoring and interagency planning collaboration. As a provider of primary health services to the community, we also provide support to many people experiencing mild to moderate mental ill health, including counselling and GP consultations, support for people experiencing family violence, victims of crime, alcohol and other drug services and family support services.

Mental ill health follows the same socio-economic gradient as physical illness, whereby people on the lowest income experience poorer mental health. Achieving better health and reducing health inequality requires a multi-facetted approach that responds to individual health factors, social structures and the systemic policies and practices that are so influential on health and wellbeing.

Key to improving the mental health of our community, and thereby improving social and economic participation, is actively addressing the social determinants of health. cohealth acknowledges that while a range of factors contribute to mental ill health and illness addressing the structural causes and contributors will significantly lessen the burden of mental illness on society and the economy.

Everyone deserves access to the physical and mental health care they require, that best meets their needs, in the places that suit them. More work is needed to prevent mental ill health, and to intervene early to prevent illnesses becoming more serious. When people do need mental health services, whether in the community or hospital, it must be safe, responsive and appropriate. Care needs to be provided as soon as it is needed and integrated with social support to best respond to conditions before they require acute, complex care.

However, as the Issues Paper describes, and the people we work with confirm, too often this does not happen. An overstretched, fragmented system means that frequently there is too little care, too late. And the people who have the greatest need for care are too often the ones who miss out or receive it too late.

Key recommendations:

- **Clear guiding principles** should underpin all responses to improve mental health, including the central involvement of people with lived experience, human rights, cultural safety, recovery oriented and trauma informed practice and carer and family inclusive practice.

- **Aboriginal and Torres Straits Islander peoples** be specifically and separately recognised in the Productivity Commission deliberations.

- **Address social determinants of health, particularly:**
    - Act on racism, stigma and discrimination
    - Increase affordable and secure housing
    - Increase Newstart Allowance
    - Remove punitive and demeaning income support compliance regimes

- Ensure that **community based psychosocial rehabilitation** services are available for all who need them.

Introduction

Almost half of Australian adults will experience mental illness in their lifetime, with 3% of the population, or nearly 800,000 people, experiencing severe mental illness each year.[1] While the severity and impact of conditions varies greatly, everyone has the right to the treatment and support that most effectively meets their needs.

Mental illness can have a significant impact on the health and wellbeing of individuals, their families and the community. People who live with mental illness are at a much greater risk of social and economic disadvantage, deprivation and poorer physical health, and have a lower life expectancy.[2] Various social, economic and physical environments – the social determinants of health – also interact to contribute to and compound the impact of mental illness.

As such, cohealth commends the Productivity Commission on recognising impact on mental health of many factors beyond health care.

Providing the right supports, at the right time and in the right setting, is critical to mitigating the impacts of mental illness, for the individual, their families and supports, and the community.

cohealth envisages a comprehensive, integrated system of supports for people experiencing mental health issues, one which provides the appropriate level and type of support at the time a person needs it. We believe everyone should have access to the treatment, care, support and recovery services that they need to enable them to live contributing lives and participate as fully as possible as members of thriving communities[3] - regardless of their economic or social circumstances.

In line with the National Mental Health Commission *Contributing Life Framework*[4], our vision for a comprehensive, integrated system includes (but is not limited to):

- Promotion of good mental health and working to prevent mental illness
- Timely support to people with more common mental health conditions, through:
    - community supports and inclusion
    - online and phone support
    - primary health response provided by GPs, private psychiatrists and allied health professionals
- Clinical care in hospitals, community and forensic settings for people with acute and severe conditions
- Diversion programs such as Prevention and Recovery Care (PARC) services which enable care in the least restrictive environments

[1] https://www.pc.gov.au/inquiries/current/mental-health/issues
[2] Victoria's 10-Year Mental Health Plan https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-plan
[3] http://mentalhealthcommission.gov.au/our-reports/our-national-report-cards/2014-contributing-lives-review.aspx
[4] http://mentalhealthcommission.gov.au/our-reports/our-national-report-cards/2014-contributing-lives-review.aspx

- Active assistance for people with severe and complex mental illness to live well in the community through:
    - rehabilitation, including psychosocial support & recovery services
    - peer and group supportive settings
    - disability support to assist social and economic participation
    - in reach support for people in trans institutional settings, such as Supported Residential Services
- Holistic, wrap around, person-centred care
- Support for people who care for someone with a mental illness
- Integrated strategies designed to address the social determinants of mental health, such as housing, employment, stigma and physical health.

All services need to be culturally appropriate, trauma informed, person centred, flexible and responsive and involve consumers and those who care for them in their planning and development.

Notwithstanding the importance of a comprehensive mental health system, as cohealth experience and expertise is primarily in providing community based services and supports, this submission has a particular focus on supporting people in the community, particularly those who have serious mental health issues, are homeless or in unstable housing and/or are from diverse communities. Our experience demonstrates that people with complex mental illness can live well in the community with the right support packages available to them.

Guiding principles underpinning mental health responses

cohealth recommends that all mental health responses, from prevention through to acute clinical care, be based on a common set of guiding principles, including:

- Experiences of people with lived experience of mental illness and distress, and those who care for them, must be the central focus of all systems, policies and programs designed to improve mental health, social and economic participation and productivity.
- Human rights
- Cultural safety and appropriateness
- Client centred
- Holistic approach, whereby mental health is considered as part of the whole person, including physical health, social connections, participation in work, study and volunteering
- Recovery oriented practice
- Trauma informed
- Codesign with consumers
- Carer and/or family inclusive practice
- Health literacy
- Flexibility
- Outcomes focussed

cohealth also urges the Productivity Commission to consider the concept of participation broadly. While we recognise the significant benefits of employment, the current reality is that there are many more job seekers than jobs available. Significant benefits in terms of social inclusion and mental wellbeing accrue from other forms of participation – volunteering, involvement in family and community life, the arts, etc - and the concept of participation should encompass all these activities.

Recommendation 1:

All mental health responses be based on clear guiding principles, including the central involvement of people with lived experience, human rights, cultural safety, recovery oriented and trauma informed practice and carer and family inclusive practice.

Aboriginal and Torres Strait Islander experience

cohealth encourages the Productivity Commission to specifically and separately recognise the needs of Aboriginal and Torres Strait Islander people, recognising the significant impact colonisation and dispossession have had on the mental health and wellbeing of these communities. Indigenous adults are three times more likely to experience high or very high levels of psychological distress than other Australians. They are also hospitalised for mental and behavioural disorders and suicide at almost twice the rate of non-Indigenous population.[5] The intergenerational impact of colonisation, trauma and marginalisation has been significant. The impact of these cultural determinants of health, and the positive benefit of self-determination, need to be specifically considered in the Commission's analysis and recommendations, to ensure that mental health responses into the future have the best chance of delivering positive outcomes.

Recommendation 2:

The Productivity Commission specifically and separately recognise the needs of Aboriginal and Torres Straits Islander peoples.

[5] http://www.naccho.org.au/wp-content/uploads/NACCHO-Pre-budget-submisison-2018.pdf

Social determinants of health[6]

"Mental health is produced socially: the presence or absence of mental health is above all a social indicator and therefore requires social, as well as individual solutions."
World Health Organization [7]

The broader social, economic and environmental structures in which people live – the social determinants of health – have an overwhelming influence on the health of individuals and communities. The unequal distribution of income and education, coupled with changing employment opportunities, reduced social expenditure and an increase in divisive narratives, means that for many, quality of life is deteriorating. Life is becoming harder for the communities we work with.

In order to change this cohealth supports a 'health in all policies' approach – where governments consider the health impacts of all policy decisions, and proactively work to address the underlying drivers of ill-health, including:

- socio-economic inequalities
- stigma and discrimination
- availability of affordable, secure housing
- social isolation and loneliness

These social determinants underlie the experience of health conditions, including mental ill health. Evidence increasingly demonstrates the significant impact on mental health of poverty, inadequate housing, racism, stigma, discrimination and experiences of violence and trauma. For this inquiry to improve the mental health of Australians, and the responses to those with mental ill health, it is essential that that Productivity Commission gives careful consideration of these matters. Any reforms aimed at improving the mental health of the nation, and responses to people who experience mental ill health, that fail to address the social determinants of health will not be as effective as they could be.

At the same time, mental health gains made through clinical treatment and community based support will not be as effective or sustainable if the circumstances people are living in do not support recovery, such as poverty, homelessness and family violence. Concerted and comprehensive policy responses are required to respond to these matters.

We cannot view mental health as separate from the whole of society we live in, including – and particularly – the values and social structures and policies that underpin society.

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[6] The conditions of daily life – "the circumstances in which people are born, grow, live, work and age – and the structural conditions in a society, which lead to unequal living conditions and affect the chances of living a healthy life". http://apo.org.au/node/55699\

[7] http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf

Social determinants affecting mental health include:

1. **Poverty**

   Low socio-economic status is the key underlying factor common to almost all people experiencing health disadvantage, and lies at the heart of health inequality. The impacts of low income are exacerbated by expensive housing, insecure employment, unemployment and underemployment; and location that is removed from services, jobs and health services.

   Poverty can be both a determinant and a consequence of poor mental health, and the relationship between low economic status and elevated incidence and prevalence of mental illness is now well recognised.[8] Studies throughout the world have demonstrated an inverse relationship between mental illness and social class[9] – that people on lower incomes have poorer mental health than those on higher incomes.

   Socio-economic disadvantage is clearly associated with poorer mental health. Barriers to opportunities such as work and education can lead to poor social connection, increased social isolation and a lack of attachment to communities. Social exclusion, and the stress of living on or under the poverty line have a negative effect on mental health.[10]

   Meeting health costs is a struggle for people on low income, with the costs of services and prescriptions harder to meet. It is also common for people on low incomes to delay seeking medical care due to cost. Health conditions are then more severe when treatment is sought, with corresponding greater impact on the individual. If you are unable to get to a service, or pay for it, then conditions go untreated. Mental health conditions are made more chronic and longer term when they're not treated.[11]

   Research has now found that poverty also has a significant influence on the development of children's brains. Disturbingly it has found that disadvantage begins at birth, is intergenerational and children from poorer socio-economic backgrounds are at greater risk of mental illness than those from more affluent circumstances.[12]

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[8] https://www.cambridge.org/core/services/aop-cambridge-core/content/view/39E6EB94B44818EDE417F181AC300DA4/S1355514600001322a.pdf/poverty_social_inequality_and_mental_health.pdf

[9] https://www.cambridge.org/core/services/aop-cambridge-core/content/view/39E6EB94B44818EDE417F181AC300DA4/S1355514600001322a.pdf/poverty_social_inequality_and_mental_health.pdf

[10] https://www.sbs.com.au/topics/life/health/article/2017/11/07/surprising-link-between-mental-illness-and-poverty

[11] https://www.sbs.com.au/topics/life/health/article/2017/11/07/surprising-link-between-mental-illness-and-poverty

[12] https://www.sbs.com.au/topics/life/culture/article/2017/11/24/how-much-do-you-know-about-science-poverty?cid=inbody:the-surprising-link-between-mental-illness-and-poverty

As such, the extreme level of poverty experienced by people reliant on income support payments, particularly Newstart Allowance, is a serious concern for mental wellbeing. This payment is now so far below all poverty benchmarks that it works against the ability of people to seek work and contributes to social isolation and marginalisation. For example, in a study examining the impact of 'Welfare to Work' policies on single mothers, the findings clearly showed that those parents receiving Newstart Allowance showed higher levels of mental health problems, compared with parents with continued eligibility for Parenting Payment Single, which is paid at a higher rate.[13]

There is now broad support – from business and industry groups, community sector, unions and civil society - for the urgent increase in Newstart payment. cohealth strongly supports these calls, recognising the benefits to the physical and mental wellbeing of individuals and families that will flow from such an overdue measure.

2. Punitive welfare systems

The last 15 years have seen increasingly punitive and inflexible requirements placed on recipients of income support payments. Based on the erroneous assumption that unemployed people will not seek work, or manage their finances and lives, responsibly and independently, an increasing array of requirements have been imposed on them. Compulsory income management, ParentsNext, harsh sanctions regimes, unreasonable job search requirements, and proposals for random drug testing, all demonise and stigmatise people, and cause significant stress.

Research is revealing the detrimental impact these approaches are having on the mental health of income support recipients. A major study in the UK has found that 'Welfare conditionality[14] was also reported as being associated with negative health outcomes including fear, anxiety and psychological distress, and is exacerbating existing health conditions, in particular in people with mental health issues.'[15]

Limitations placed on other forms of assistance can have unintended consequences on people with mental ill health. For example, if parents are unable to meet the activity test for the Federal Childcare Subsidy access to child care can be restricted. For people with mental illness this can make it particularly hard for them to participate in treatment or manage their own health. Reduced access to education and care can impact on children's wellbeing, through missing out on the developmental benefits of early childhood education.

3. Neoliberalism and individualism

Our culture has evolved to one that promotes individualism and materialism, yet this disconnection with each other and the community we live in is increasingly recognised as a major contributor to mental ill health. Studies have shown that

[13] https://onlinelibrary.wiley.com/doi/full/10.1111/1753-6405.12304
[14] The linking of welfare rights to specific obligations or patterns of behaviour
[15] https://basicincome.org/news/2018/07/united-kingdom-study-suggests-that-welfare-conditionality-does-more-harm-than-good/

materialism, for example, is associated with dissatisfaction, depression, anxiety and isolation.[16] The very social structure that we now live in has exacerbated levels of anxiety and depression.[17] As stress and insecurity play a significant role in mental ill health that it is not surprising that the increase in mental ill health has occurred at the same time as the dramatic rise in precarious and casualised work.

Government policies – across all domains - must be cognisant of this link, and work towards enhancing community connectedness and a sense of belonging, rather than exacerbating isolation and marginalisation.

4. Racism

There is now substantial evidence about the many health impacts on individuals of racism. As a recent Victorian Department of Health and Human Services report *Racism in Victoria and what it means for the health of Victorians* states:

"There is an abundance of high-quality scientific studies that show that racism is a key determinant of the health of Aboriginal Australians and other minority groups. This report shows that racism is harmful to the health of those who are its victims. Moreover, racism is not just harmful to mental health, it is also harmful to physical health."[18]

Racism has a negative effect on health both directly and indirectly.

For individuals, the harmful effects of racism on mental health include conditions such as psychological distress, depression, anxiety, post-traumatic stress disorder, psychosis and substance abuse disorders.[19] We now also know that the harmful physical health effects of racism are just as significant, including cardiovascular disease, hypertension, adult-onset asthma, cancer and accelerated biological ageing. Racially motivated assaults of course have both physical and mental health consequences.

The impacts of racism go well beyond the individual. Alarmingly, there is now also evidence that maternal exposure to racism elicits a physiological stress response causing subtle but harmful effects on a foetus that can continue into adulthood.[20]

More broadly, systemic racism serves to maintain or exacerbate the unequal distribution of opportunity across ethnic groups through the way our systems and

[16] https://www.richardeckersley.com.au/attachments/IJEpi__culture_1.pdf
[17] https://inthesetimes.com/article/20930/depressed-anxious-blame-neoliberalism
[18] https://www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians/survey-data-and-reports/racism-in-victoria
[19] https://www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians/survey-data-and-reports/racism-in-victoria
[20] https://www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians/survey-data-and-reports/racism-in-victoria

services are structured and delivered. As a result, people may not seek the support and services they need and are entitled to.

Racism reduces access to employment, housing and education, resulting in low socio-economic status[21], and as socio-economic status declines, so does mental and physical health.

5. Stigma and discrimination

Emerging evidence[22] indicates that stigma and discrimination are also fundamental causes of health inequalities. Stigma directly influences the physical and mental health outcomes of people with specific characteristics (eg their race, sexuality or gender identity, or particular illness). Stigma and discrimination also limits or disrupts access to the structural, interpersonal and psychological resources that could otherwise be used by individuals or communities to improve health. People experiencing stigma may not seek care if they perceive providers to be unwelcoming or unsafe. Health systems may not provide the same level of care to particular groups due to inappropriate assumptions made about their health and behaviour.

Actions to reduce racism, stigma and discrimination will improve the mental health of the community.

6. Inadequate Housing

Secure, adequate housing is fundamental to the wellbeing of individuals and families.

The negative impacts of homelessness on physical and mental health are well recognised, including depression and other mental health problems.[23] Not only does the experience of homelessness exacerbate existing mental illness, but it can also precipitate the deterioration of mental health. Precarious housing, including insecure tenure, poor quality housing and overcrowding also impacts on mental health, as does ongoing uncertainty and stress about ability to meet the costs of housing (rent or mortgage).[24]

Research has concluded that governments can improve the mental health of economically vulnerable populations through more supportive housing policies.[25]

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[21] https://www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians/survey-data-and-reports/racism-in-victoria

[22] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3682466/

[23] http://www.nwhn.net.au/Health-Homelessness.aspx

[24] Mallett, S, et al (2011). Precarious housing and health inequalities: what are the links? Summary report. https://www.vichealth.vic.gov.au/~/media/resourcecentre/publicationsandresources/health%20inequalities/precarious%20housing/precarious%20housing_summary%20report_web.pdf?la=en

[25] Bentley, R et al (2016) Housing affordability, tenure and mental health in Australia and the United Kingdom: a comparative panel analysis, Housing Studies, 31:2, 208-222, DOI: 10.1080/02673037.2015.1070796

With current high housing costs, and more people experiencing homelessness, it is critical for mental health that governments of all levels take urgent action to increase the supply of affordable and social housing.

Recommendation 3:

The Productivity Commission include consideration of the social determinants of mental health in the Inquiry, and urge the Government take action to address them, particularly:

- **Reduce poverty through an urgent increase to Newstart Allowance**
- **Remove punitive and confusing income support compliance regimes**
- **Move away from precarious and insecure employment arrangements**
- **Act to reduce racism, stigma and discrimination, both overt and systemic**
- **Increase social and affordable housing**

Responses to Issues Paper themes

The following comments on selected themes raised in the Issues Paper reflect cohealth's experience providing community based mental health services, particularly to people with serious mental illness and complex needs. This work has emphasised the critical need for a greater focus on prevention and early intervention in the community where people live, to reduce the impact of mental ill health. For those who need support, our experience demonstrates the value of community based programs. However, in Victoria in recent years many of these programs have closed, leading to poorer outcomes for those who previously relied on them.

2.1.b Specific health concerns

Too often the physical health concerns of people with mental ill health have not received sufficient attention. As a result, people with mental illness experience poorer physical health than the general population. People living with a mental illness are twice as likely to have cardiovascular or respiratory disease and diabetes and comprise approximately one third of all avoidable deaths. People living with a severe mental illness are particularly at risk and are likely to die between 14 and 23 years earlier than the general population.

The *Equally Well Consensus Statement: Improving the physical health and wellbeing of people living with mental illness in Australia*[26] identifies six essential elements that provide guidance to health service organisations to ensure they can recognise and respond to the health needs of people living with mental illness:

1. A holistic, person centred, trauma informed approach to physical and mental health and wellbeing
2. Effective promotion, prevention and early intervention
3. Equity of access to all services
4. Improving quality of health care
5. Care coordination and regional integration across health, mental health and other services and sectors which enable a contributing life
6. Monitoring of progress towards improved physical health and wellbeing

cohealth, and our founding organisations, has provided mental health services and supports for over 30 years in close conjunction with our various medical, nursing, dental and allied health services. Our approach recognises the critical importance of providing integrated support and care for the whole person, incorporating physical, mental and social wellbeing.

Central to the success of our model is the co-location of mental health services in a community health setting. This is a multi-disciplinary setting providing services that can include medical, nursing, dental, allied health and social support services - including alcohol and drug, family violence, child and family services, Aboriginal and refugee

[26] https://www.equallywell.org.au/wp-content/uploads/2018/12/Equally-Well-National-Consensus-Booklet-47537.pdf

health, and victims assistance programs - in places consumers feel comfortable in. This setting facilitates referrals between services and supports, communication about client needs and service options and comprehensive care planning and coordination.

As a result, medical and allied health workers are experienced working with people with mental illness, including those with a serious mental illness. Similarly, mental health workers are attuned to physical health needs of consumers, with assessment and monitoring of these included as part of the engagement with clients and the development of recovery plans.

The mental health needs of people with physical health problems also needs specific consideration, particularly as physical illness can make people more vulnerable to developing mental ill health. Greater awareness among health practitioners about the risks of mental illness in all settings (acute, primary and community care, rehabilitation, outreach and home-based services) will facilitate early intervention. Provision of training and resources to practitioners, and accessible referral pathways, can ensure that people are identified and referred to support and treatment early, before mental health conditions become severe or entrenched.

Recommendation 4:

Mental health care should be integrated with multidisciplinary physical health care and social support services, and based in the community where people live, where ever possible.

Recommendation 5:

Increase education and awareness of health care practitioners about mental health, particularly the health needs of people with mental illness.

2.2.a Housing and social services

The shortcomings of the current housing market are well documented – homelessness is increasing, 1 in 9 people are paying more for housing than they can afford and rental properties in many areas are scarce, costly and too often of poor quality.[27] The stresses associated with the lack of housing and precarious housing are a significant contributor to mental ill health. Urgent action to increase crisis, social and affordable housing would go a long way to improving mental health across the community in general. 500,000 additional social and affordable homes are needed by 2026 to address this need.[28]

Recommendation 6:

That the Government increase the supply of social and affordable housing as a matter of urgency.

[27] https://everybodyshome.com.au/our-campaign/more-social-and-affordable-homes/
[28] https://everybodyshome.com.au/our-campaign/more-social-and-affordable-homes/

To respond to the needs of people experiencing homelessness, including those who experience mental illness, cohealth has developed a range of responses. For some people, homelessness is a result of mental illness; for others mental illness develops due to the experience of homelessness. Key to responding effectively is basing responses on the guiding principles outlined earlier – including using a person centred, trauma informed, recovery based approach – in which integrated responses are provided by a range of services.

By way of example, cohealth is a key partner in the *Homeless Outreach Mental Health Service (HOMHS)*, which responds to clients with intersecting homelessness and mental illness needs. HOMHS demonstrates the importance of multi-disciplinary teams working in partnership to provide integrated supports to consumers.

The service is located at the cohealth site in Melbourne's CBD (Central City Community Health Service) and offers intensive clinical and community mental health care and case management to people with severe and enduring mental illness and a history of chronic homelessness. cohealth, as the lead agency, partners with three agencies to deliver the program – Inner West Area Mental Health Service who provide clinical mental health services; McAuley Community Services for Women who have specialist skills in engaging the growing number of women experiencing homelessness; and Launch Housing who provide links to stable and affordable housing. The HOMHS interagency multidisciplinary team offers assessment, integrated clinical treatment, recovery support, housing support and care coordination, scaled in intensity to meet each client's needs, values and goals.

Through this interdisciplinary and multi-agency approach, HOMHS improves access for clients to mental health services, housing support – including stabilising housing - physical health care, and practical assistance. Examples of positive outcomes from the program include: 86% of clients who were placed in stable housing have maintained it long term; 46% were linked to a GP where they previously weren't; and there was a 42% reduction in emergency department admissions. The program's success in improving health and wellbeing lies in the intensive support provided to clients, combined with the joint clinical and community mental health supports and other support structures, including housing services.

Recommendation 7:

Responses for people experiencing homelessness should provide holistic, wrap around support, that includes mental health services, housing support, physical health care and other relevant social services,

2.2.b Income support and social services

i. Service gaps for people with a psychosocial disability who are ineligible for NDIS

As the NDIS has rolled out, service gaps have arisen for people with a psychosocial disability who are:

- not ineligible for the NDIS
- eligible but are unable to access the NDIS
- eligible, but do not received the psychosocial rehabilitation they require under the NDIS model

As a result of a number of policy decisions[29], psychosocial rehabilitation supports have been significantly reduced in Victoria in recent years. Specifically, Victorian state funding for community managed mental health services[30] has been transferred to the NDIS as part of NDIS funding arrangements. Victoria is the only state where this has occurred. As a result, Mental Health Community Support Service (MHCSS) is progressively ceasing as the NDIS rolls out across the state. At the same time, a number of Commonwealth funded programs are also ceasing, and their funding transferring to the NDIS, including those providing 'low barrier to service'.[31]

The cumulative effect of these changes has been fewer specialised individual rehabilitation supports, and reduced group, peer and carers supports.

While cohealth has welcomed recent funding commitments by both the federal and Victorian governments to meet the needs of people ineligible for the NDIS, we still hold serious concerns about whether the needs of people with serious mental illness will be met under the current arrangements. How these new state and federal systems and the NDIS will work together to support an integrated approach to recovery oriented psychosocial rehabilitation also needs to be clarified.

Effective psychosocial rehabilitation support - that works towards social and economic participation - requires an explicit recovery oriented focus, sophisticated case management, workers with specialised knowledge, skills and qualifications in working with people with a psychosocial disability, and a clear understanding of the intersecting needs relating to acute treatment, rehabilitation, housing, physical health, employment, social connectedness and the like. Continuity of care and an ongoing therapeutic relationship between the support worker and the person with a psychosocial disability is of critical importance in recovery[32], and allows for ongoing oversight of their condition.

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[29] In 2014 community managed mental health services were recommissioned. With the current roll out of the NDIS, funding for these services has been transferred to the NDIS.

[30] Specifically, Mental Health Community Support Service (MCHSS) funding

[31] https://www.theguardian.com/australia-news/2018/jan/17/almost-75-of-people-on-mental-health-programs-left-without-ndis-support

[32] Slade M, McDaid D, Shepherd G, Williams S, Repper J (2017) Recovery: the Business case, Nottingham: ImROC https://imroc.org/resources/14-recovery-business-case/

We remain concerned that the NDIS will not provide the recovery oriented psychosocial rehabilitation support that leads to increased social and economic participation. The disability support provided by the NDIS is of a practical, task-oriented nature and 'is not targeted at building the underlying capacity and environmental supports that is the hallmark of psychiatric rehabilitation'[33], and as such it is fundamentally different to recovery oriented psychosocial support.

Similarly, we have serious concerns as to how the needs will be met of people who require assertive outreach and support to be connected with service system options, including those living in trans institutional settings, such as Supported Residential Services.

Recovery oriented psychosocial rehabilitation support needs to remain available, and in community-based settings. cohealth believes that Victorian community health services provide an ideal platform – and model – for this work. Community health services provide integrated primary health services including general practice, nursing, allied health, mental health, alcohol and other drugs, and social support services. They have well established relationships with vulnerable communities, and expertise in primary prevention and health promotion that use participatory, codesign approaches tailored to specific communities.

Recommendation 8:

Ensure community based psychosocial rehabilitation, based on recovery oriented practice, is available for those who need it. Community health services provide an ideal platform for the provision of these services.

ii. Income support payment rates & meeting the needs of those with fluctuating capacity to work

Income support payment rates are insufficient to enable those locked out of paid work to afford basic essentials such as a roof over their head and food on the table. People have to make difficult choices between eating a meal, paying a bill or maintaining their health. This is particularly so for people receiving Newstart Allowance. As eligibility for the Disability Support Pension has tightened in recent years, the number of people with a mental illness who are trying to survive on Newstart has increased. The Newstart payment rate is now significantly below all poverty benchmarks and has not been increased in real terms for 24 years.

The stress of living on such a low income, the stigma attached to unemployment and the onerous and demeaning processes required to receive the payment,

[33] Collister, L (2015) "Rehabilitation and disability support: are they the same?", VICSERV New Paradigm Spring 2015 https://www.mhvic.org.au/policy-publications/newparadigm/past-edition

combine to the place great pressure on people's mental wellbeing. This stress can be both a contributing factor to the development of mental health issues and exacerbate existing conditions.

In line with calls from a wide cross section of community services, business groups, unions and civil society, cohealth urges an immediate increase of the Newstart Allowance of $75 per week.

In addition to the low payment rate the income support system is not well designed to meet the needs of people with fluctuating capacity to work. It is highly rigid, complex and penalties for missing appointments and deadlines (activities that can pose particular challenges for people experiencing mental illness) can result in loss of payments. Greater flexibility, more accommodating processes and more reasonable evidence requirements are needed to enable people who are unable to work to move on and off payments more easily as their needs change.

Recommendation 9:

That the Government increase the rate of Newstart Allowance by $75 per week as a matter of urgency.

Recommendation 10:

Improve the flexibility and responsiveness of income support systems to better accommodate those with fluctuating capacity to work.

ii. Is there evidence that mental illness-related income support payments reduce the propensity of some recipients to seek employment?

In light of our comments about the social determinants of mental health, above, cohealth is disturbed by the negative phrasing of this question. In our experience people living with mental health conditions – indeed all people experiencing unemployment - are keen to work. They are very aware of the benefits of employment, particularly higher income, social status and social and community connections. However, they face significant barriers in an economy where there are eight jobseekers for every available job. Insufficient jobs, the stigma still associated with mental illness, limited workplace adjustments to accommodate the particular needs of people with mental ill health, and assumptions made by employers about time out of the workforce are the real barriers to employment. Indeed, research has shown that the assumption of a lack of willingness to work is

unwarranted, harmful to people with a disability and counter-productive to engagement in employment.[34]

Increasing employment of people with a mental illness requires a comprehensive strategy that focuses on the adequacy of the income support system, accessible education and employment, an employment services system that is able to meet a diversity of aspirations and skills[35], and action to address the stigma that is a significant barrier to employment.

Recommendation 11:

Policy makers address the systemic barriers to employment of people with mental illness and move away from the view that places responsibility for unemployment on individual deficits.

2.2.c. Facilitating social participation and inclusion

The Issues Paper identifies that programs in areas as diverse as the arts, music, cultural activities and sports aim to reduce social exclusion. cohealth facilitates a range of successful activities and programs, tailored for the needs and interests of particular groups that face barriers to social participation. These include:

- Billabong BBQ – a weekly BBQ for Aboriginal and Torres Strait Islander people to get together and connect with the mob.
- cohealth Kangaroos – providing access to team sports for people who find it difficult to access mainstream sports clubs.
- Arts Generator - working in partnership with communities to unlock creative potential and build connections by producing high quality, cutting edge art and art experiences. Arts Generator works with communities experiencing structural disadvantage in the western region and inner north of Melbourne, specialising in engagement with a range of African communities, in particular the Melbourne South Sudanese community.
- Youth Residential Rehabilitation Programs - for young people with multiple and complex needs including related to serious mental health issues, substance misuse issues and complex trauma. The 12-month program has a therapeutic focus which emphasises developmentally appropriate (early) intervention responses and is intended as a transition point rather than a landing place. The program responds holistically to each young resident and actively engages with families, clinical service providers, recreation, employment support and education providers.

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34 https://www.aspc.unsw.edu.au/sites/www.aspc.unsw.edu.au/files/uploads/aspc_historical_conferences/2009/paper290.pdf

35 https://www.aspc.unsw.edu.au/sites/www.aspc.unsw.edu.au/files/uploads/aspc_historical_conferences/2009/paper290.pdf

- Bicultural interns - members of refugee and asylum seeker communities who are bilingual, have a strong connection to their community and a deep understanding of its culture and traditions. This project aims to strengthen partnerships with people from refugee and asylum seeker backgrounds, better understand their interests and needs, and ensure services are culturally appropriate, accessible and effective.
- Older Persons Highrise Program - Helping older people in high rise housing feel safer, more independent, secure and building community connections

Regardless of whether the programs are therapeutically oriented, or arts and recreation based, critical to their success is a clear foundation in the guiding principles outlined earlier. Activities need to be codesigned with participants and be culturally safe and appropriate, provide safe places, be trauma informed and recognise the barriers to social inclusion facing the particular group.

Social participation and inclusion for people with more significant mental illness can require additional support to assist them engage with their community and improve social and economic participation. Peer workers are highly valuable in this work, particularly when they can provide consistent, ongoing support. The following lived experience account illustrates the value of support from a peer worker, using recovery oriented practice.

The investment in this approach has markedly improved this person's social and economic participation, through connection to social groups and involvement in volunteering, and leading to paid employment.

Lived experience account 1:

A friend of mine, a bit over two years ago now recommended me to apply to PHAMS. I manage depression and anxiety and have a history of complex post-traumatic stress, when I spoke to my local doctor they put me in touch with cohealth. At cohealth I was paired with a peer worker who worked with me one-one using the collaborative recovery model. I also completed the Flourish program with them and later on joined a coheath initiated local support group for people living with mental illness. I found out about this group through a flyer at the local school where my kids go.

Through my time working with the peer worker the most significant change has been becoming connected to the local community. At the time I had lived in the area for 8 years but felt disconnected and isolated. Most of my days were spent getting up, getting kids off to school and coming home and hanging around the house. As my close friends were not in the area I didn't have much to do other than hang around until pick-up time, I felt very isolated.

The peer worker at cohealth helped me gain the confidence to get involved with social groups and volunteer groups. I wouldn't have thought of going to the Neighbourhood House to volunteer without my peer worker suggesting it. Now I have more things to do. My volunteering which started two years ago at the Neighbourhood House is still going, one thing I do there is that I'm part of a regular sewing group. I also help out at various local festivals, instead of just going to them I'm involved in running them and am comfortable with that. My

volunteering at the Neighbourhood House has also led to some paid work teaching computer and knitting classes, I also did some back-fill work when one person returned from mat leave.

What it all means is I know I can go down to the shops and run into someone I know and even if I don't see someone, I feel more part of the community. Into the future I hope the connections continue and that I won't feel so isolated, this is important as my children are getting older. I also hope to build up the employment I have to a few days a week.

Recommendation 12:

Social participation and inclusion programs should be appropriate to the needs of particular groups, and based on clear guiding principles.

Recommendation 13:

Increase investment to assist social participation and inclusion of people with more serious mental illness, particularly though peer support programs.

2.3.a Justice system

People with mental illness are over-represented in the justice system. Much of this is a result of systemic issues such as inadequate legal aid funding, and limited housing and support options. Too often people with mental illness end up in the justice system, when their needs and issues would be more effectively be responded to elsewhere. As such, addressing the social determinants of health, and adequately resourcing services that provide support is critical to reducing the number of people with mental illness in the justice system.

Those who are involved in the justice system experience poorer mental and physical health than the general community, and this often worsens when people leave prison. For many the return to community and the associated shame and stigma they feel poses one of the most significant barriers to successful reintegration into the community. Critical service gaps include the lack of support for reintegration and limited continuity of care when returning to the community after time in prison.

In an approach designed to address this gap, cohealth has established a partnership with Forensicare to provide psycho-social support to patients transitioning from Thomas Embling Hospital (TEH), a forensic mental health facility in Melbourne. Our work is based on the guiding principles outlined earlier, with the addition of tailored practices developed to address the challenges faced by consumers transitioning from TEH, including:

- Meeting clients in TEH prior to their discharge, and collaborative work with clinical staff to support initial engagement and overcome the significant distrust consumers often have of services and authorities.

- Care coordination to address potential gaps in patients' interrelated medical, social, developmental, behavioural, educational, and financial needs in order to achieve optimal community integration outcomes.
- Streamlined community referrals and supports based on careful planning – for example, streamlined hospital admissions to treat ongoing mental health issues where required.
- Collaborative goal setting focused on a future in which they are healthy and free from criminal justice involvement.

The positive outcomes from investing in an integrated and collaborative approach are described in the words of one of our community health workers, as they describe their work with a man following his release from prison:

Lived experience account 2:

I'm a community mental health worker at cohealth. What we do isn't just intervention, it's prevention. A strong example of this is through work a client and I undertook together in 2018-19. At this time Steve was in his early 40's and had just been released from prison after four years, at the time we started working together he was staying on a friend's couch and looking to re-adjust to life in the community. The referral had been set-up as part of his prison discharge plan to support Steve with his mental health.*

For Steve managing his mental health had been a contributing factor to being in prison and early on he told me "it would be very easy to re-offend". How I worked with Steve was very important. The first task was to build a trusting relationship, we would have got nowhere if Steve felt judged or stigmatised by me. Using a trauma informed approach was also important given the forensic context. From this we were able to uncover goals that mattered to Steve.

The most significant change was working with Steve so he could build his confidence and capabilities to self-advocate with services and engage with community groups. When we started working together Steve had just come out of prison. He was having trouble adjusting to "being free" and managing his own time after the routine of prison. He was also anxious about being able to achieve anything with the stigma of prison. In our early meetings with services he would only speak when spoken to, avoided eye contact and tended to agree rather than question.

As part of our work together we agreed to focus on confidence building so Steve could engage with services and the broader community. As a community based worker I had the time and the flexibility to stay with Steve for his journey. In practice this meant meeting fortnightly to discuss what was coming up and me heading along to support Steve in his interactions with services and the community. Over time I did less and he did more in these meetings.

It led to so much for Steve. Not only had he not re-offended or become homeless, he connected to other health services, and joined a community gym. In relation to housing, initially Steve was offered a room in a share house with others who had come out of prison. Without the work we had done Steve may have just accepted this rather than advocate for something that would best support him not to re-offend. In the community I went with him to his first gym visit, giving him the confidence to keep going on his own. One of the other challenges we worked though was Steve's anxiety around going for jobs with a criminal record, we set goals around this and faced it head on. He got a job as a mechanic.

As a worker how I was supported also contributed to me being able to provide consistent and quality support. Debriefing was essential as I would be hearing some pretty heavy stuff from time inside prison. Getting team feedback through reflective practice and from peer workers was also integral to troubleshoot what directions I could go with Steve.

This is an important story of change as it shows that when you're working with someone around recovery, providing non-judgemental supports and options enables support to be life changing.

** Name changed to ensure privacy*

Recommendation 14:

Increase investment in support to assist people leaving prison connect with services and reintegrate into the community.

2.4 Employment and workforce

Consistent, appropriate support based on recovery oriented practice provides a sound foundation to promote increased participation in community and employment of people with serious mental illness. *Lived Experience accounts 1* and *2* both illustrate this approach well.

A group of cohealth workers, including peer workers, those with lived experience and others, have also identified a number of key success factors that contribute to social and economic participation:

- importance of peer involvement
- feeling safe and accepted
- to feel valued
- positive approaches work much better than punitive or punishing ones
- involvement in decision making, including mentoring to achieve this
- value of volunteering

Expanding and developing the peer workforce is key to enhancing social and economic participation of people with mental illness. Peer workers – people with lived experience of mental illness, recovery or caring for someone with a mental illness who have a specific and deliberate role in mental health support services - are an integral part of recovery oriented practice and have been shown to support recovery.[36] *Lived Experience account 1* illustrates the value of this approach.

A cohealth consumer has described the benefits: "Peers who have experience of mental health get it in a way that mental health professionals sometimes don't. With

[36] Slade M, McDaid D, Shepherd G, Williams S, Repper J (2017) Recovery: the Business case, Nottingham: ImROC https://imroc.org/resources/14-recovery-business-case/

some professions it was like hitting your head against a brick wall, with peers it was a lot easier to share".

One of our peer workers described "The system is deficit based and clients have often struggled to identify hope and to believe that they can live a full productive life. The lived experience perspective brings a shared understanding and compassion".

However, this workforce needs development and support as another worker has described:

> "Supports are required for peer workers to do their job well. There needs to be Peer to Peer supervision, accredited pathways and more professional development opportunities. More EFT is also required for Peer work positions. There is a fallacy that Peer workers can't do full time work which I believe to be quite discriminatory. I want my co-workers to not see me as different, but to see me as another part of the team that is complementary to the work they are doing. We need more integration in the team and to not be in silo roles. I see a whole new workforce of consumers moving into the peer sector with the lived experience worker nurturing them along the way, saying "you can do this". Peer work helps consumers to make sense of their experiences and make something out of what has happened to them."

Realising the potential benefits of the peer workforce in promoting recovery also requires organisational commitment, including to recovery focussed work environments[37]; challenging stigma about mental illness to ensure workplaces are safe and supportive for peer workers; developing a range of roles for peer workers, including senior ones; and accommodating reasonable adjustments.

Volunteering can provide a valuable pathway to both community participation and employment. For a number of years cohealth has run *Connecting Mates and Mentors (CMM)* a program linking people experiencing mental health issues who are socially isolated with volunteers on a one-on-one basis to support recovery through increased community engagement and social interaction. Matches are made based on shared interests and preferred activities. *Lived Experience account 3* illustrates the benefits to both the consumer and the volunteer of this program. Regrettably, despite the success of CMM, it will close in mid-2019 as funding ceases.

Lived Experience account 3

Mohammed: Mohammed commenced participating in the CMM program in early 2016. At the time he had been supported by a Community Mental Health outreach support worker for 2 years. Mohammed was born overseas and immigrated to Australia as an adult leaving behind most of his family. After arriving in Australia, he had experienced a tragic accident and the breakdown of his marriage. Mohammed experienced significant depression, anxiety and consequently, social isolation. He advised that did not wish to reconnect with people he knew*

[37] Byrne, L. (2014). A grounded theory study of lived experience mental health practitioners within the wider workforce. Unpublished doctoral thesis. Central Queensland University, Rockhampton, Australia.

due to the stigma associated with his experiences. Mohammed shared his passion for going to cricket matches and was keen to introduce his dog to his mate.

Ella: Ella commenced with the CMM program as a young volunteer in 2016. She had previously volunteered mentoring at a school and as a companion in an aged care facility. Throughout her time with the program Ella worked part time and attended university studying in a related field. She identified that she had a lived experience of managing anxiety and communicated her passion for spending time with animals.*

Ella & Mohammed as mates: Ella and Mohammed were matched through the CMM program as mates in late 2017. Both had been previously enjoyed their time as mates with other program participants. Ella and Mohammed were matched due to their shared interests and their love of animals.

Both Ella and Mohammed committed to the program and their relationship with each other from the outset, meeting regularly and participating together in a range of community activities including attending sporting events, viewing movies, visiting animal charities and meeting at cafes (with Mohammed's pet dog). During reviews of their match they both expressed consistently that they are enjoying meetings and wanted to continue meeting with each other through the program. Mohammed noted a highlight of their time together as going to the cricket with Ella, something that he had not done for several years. Mohammed has recently reported feeling more confident socially and more motivated to leave his home and take on new challenges. In the past 3 months Mohammed and Ella decided to take on the challenge of connecting socially with groups in the community, attending several meet up groups together.

Other opportunities: After participating in the CMM program for approximately a year both Mohammed and Ella were invited to participate separately in other program activities. Mohammed has enthusiastically taken on the role of a Consumer Representative on the CMM interview panel, interviewing potential volunteers of the program. Ella has contributed articles to the CMM program newsletter, attended program events and provided the program with considerations for supporting volunteers.

Early this year Mohammed expressed interest in becoming a volunteer with the CMM program to support others. After being advised that the program will not be continuing after June 2019, both he and Ella have sought other community based volunteering opportunities. Mohammed and Ella have both applied to volunteer with community support organisations in new roles.

** Names have been changed to ensure privacy*

Unpaid care work is also a critical part of the support provided to people with mental illness that often goes unrecognised. However, caring responsibilities can impact on the carers own health and economic and social participation. Supporting the capacity and sustainability for unpaid carers in their role should be integral to any service system.

Recommendation 15:

Expand and develop the peer workforce.

Recommendation 16:

Recognise and support the value of volunteering in enhancing community participation and employment.

3. Governance and funding arrangements

The mental health sector in Victoria has undergone significant change in recent years. Community based mental health services were recommissioned five years ago resulting in significant change in the sector. The more recent NDIS rollout has resulted in further significant change – including, as mentioned earlier, the loss of all Mental Health Community Support Service funding, the community based psychosocial support services for people with a serious mental illness. As the resulting support gaps have become more apparent, both the federal and state governments have released short term funding to meet some of the resultant needs. While welcome, mental health service providers had been warning about the impending service gaps since the inception of the NDIS, yet only at the eleventh hour has some effort has been made to address the service gaps.

Throughout these changes we have seen the impact on the people we work with, particularly those with serious mental illness. Despite the best efforts of the dedicated workforce, too many people have been left without supports, and their condition has deteriorated. Others no longer have the consistent worker that facilitates the trusting relationship so important for the recovery that leads to greater participation.

We have also witnessed a significant diminishing of a skilled and experienced workforce as services close or move to a disability support model that pays significantly lower salaries for a very different type of work.

Future funding and governance arrangements must ensure that the wellbeing of consumers is the central priority. To this end cohealth recommends that:

- Funding periods be of sufficient length to enable program development, comprehensive and ongoing evaluation, and to implement improvements. Adequate time is required to build workforce capacity, including skilled staff and peer workforce, and to build and mature the effective partnerships that produce strong outcomes. The Productivity Commission recommended seven-year contracts for family services[38] to address these same issues. We suggest that a similar timeframe be considered for the funding of mental health services.
- Six-month notice must be given of funding renewals or any significant changes to best manage the workforce and ensure the continuity of care for consumers essential for the development of trusting relationships.

[38] https://www.pc.gov.au/inquiries/completed/human-services/reforms/report

- There be recognition that consumer managed care approach does not work for all people, particularly those with psychosocial disability or complex needs. Alternative funding arrangements, such as block funding, needs to continue to ensure the needs of these people can be met.
- Investment in robust impact and outcome measurement and evaluation and reduced reporting on inputs and outputs. In transition to this approach reporting and accountability requirements need to be streamlined. Currently different sources of funding all come with their own reporting requirements, despite sharing similarities. The resources required to complete multiple reports is significant and would be more effectively used providing services to consumers.

Recommendation 17:

Ensure that the wellbeing of consumers, and continuity of care, remains the central priority when there are any changes to funding arrangements.

Recommendation 18:

Funding periods be of sufficient duration for program development, evaluation and improvements. A seven year period is in line with previous Productivity Commission recommendations.

Recommendation 19:

Invest in robust impact and outcome measurement and evaluation.