cohealth
care for all

Submission to:

Royal Commission into Victoria's Mental Health System

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Contents

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 have recently included 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.

This submission has been developed through significant contributions from cohealth consumers, community members and workers. Their honest accounts and passion to improve mental health services, particularly for people who are most disadvantaged, has given real depth to our work. To those who have generously shared their lived experience of mental health issues – as a consumer, worker or carer - we thank you for your courage and insight.

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Executive summary

cohealth welcomes the opportunity to provide a submission to the *Royal Commission into Victoria's Mental Health System*. In recent times cohealth has provided 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 not just to individual health factors but also to the 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, the economy and the system.

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 people we work with confirm, too often this does not happen. The system is in many cases poorly designed and the models of care do not meet contemporary expectations. 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 priorities for change

It is clear that improving the mental health of Victorians will require a comprehensive effort across all of society and our institutions. Our submission addresses only on a small part of this complex system, and we recognise that we barely touch on critical areas such as: community wide mental health promotion, including in schools and workplaces; suicide prevention; acute inpatient services and crisis responses provided through emergency departments and Area Mental Health Services; and the differences between the public and private mental health systems, to name a few. Other organisations and individuals have greater expertise to comment on these areas.

With such complexity, identifying priority areas for change is a challenge. Nonetheless, cohealth identifies the following areas where we believe early change will make a

significant difference to the lives of individuals, those who care for them, and the community at large:

- Investment in approaches that promote social inclusion and cohesion, including anti-racism programs.

  Addressing the racism and discrimination that drives exclusion and has such a detrimental impact on mental wellbeing will contribute to improved health across the community.

- Concurrent increases in investment in both clinical and community-based mental health services and support.

  An initial increase in investment in clinical care will enable earlier and more effective treatment of those who are in crisis and need acute care. People in crisis should not have to wait to receive care, and they need to be able to receive it for as long as is clinically indicated.

  At the same time, investing in community-based services will enable more people to receive support and care early and prevent their condition declining to the point where they are in crisis and needing acute care. This has clear personal benefits, with people remaining more connected to family, work and social networks, along with financial savings through the reduced costs to the acute health system.

- Urgently meeting the needs of people with serious mental illness who are currently falling through the gaps as the services that have previously supported them close. cohealth urges the full re-instatement and strengthening of the community-based mental health programs that support these people. We propose that community health services are particularly well positioned to provide these services in an integrated, wrap manner with other health and social support services.

- Support should be prioritised for those who experience marginalisation and disadvantage, and may have limited resources – financial, social, personal - to draw on or to obtain support in other ways.

Recommendations

Guiding principles

Recommendation 1

The 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.

Recommendation 2

All mental health responses be based on clear guiding principles, including human rights, cultural safety, recovery-oriented and trauma informed practice and carer and family inclusive practice.

Aboriginal and Torres Strait Islander experience

Recommendation 3

Aboriginal and Torres Strait Islander leadership and presence is required across all parts of the mental health system.

Social determinants of mental health

Recommendation 4

The Royal Commission specifically consider the social determinants of mental health and identify actions to address them, particularly through:

- Reducing poverty and the impacts of low income
- Acting on racism, stigma and discrimination
- Increasing affordable and secure housing

Preventing mental ill health

Recommendation 5

Increase investment in a range of culturally relevant community building programs to enhance social inclusion.

Recommendation 6

Increase investment in mental health services for parents both as an investment in their wellbeing and as a critical approach to preventing future mental health issues for their children.

Recommendation 7

Increase investment in programs that promote awareness of mental health and illness, and the services and supports available, using appropriate approaches for diverse communities.

Improving mental health outcomes and access to services

Recommendation 8

Invest significantly in community-based early intervention and support services to shift the orientation of the mental health system towards keeping people well and reducing the need for acute care. This needs to include significant re-investment in community-based psychosocial rehabilitation, based on recovery-oriented practice, for those who need it. Community health services provide an ideal platform to provide these services.

Recommendation 9

Mental health care should be integrated with multidisciplinary physical health care and social support services, and based in the community where people live, where possible. Integration must be supported with adequate funding to enable collaborative care, streamlined information sharing processes and increased uptake of Advance Statements and Nominated Persons.

Recommendation 10

Develop the mental health knowledge of the workforce through increasing the peer workforce and enhancing the education and awareness of health care practitioners about mental health, including the health needs of people with mental illness.

Recommendation 11

Governance arrangements need to ensure that outcomes and continuity of care are central priorities. Investment in robust impact and outcome measurement and evaluation is required, as is funding periods that are of sufficient duration to enable cycles of program development, evaluation and improvement.

Responding to the needs of specific groups

Recommendation 12

Ensure all services are culturally safe and reflect and respond to the specific needs of diverse communities through: supporting community and consumer led services; employing workers from these communities; ensuring services recognise the complex experiences that contribute to mental ill health; and ensuring mainstream services are culturally safe through training and employment practices.

Recommendation 13

Increase investment in holistic wrap around services to support people who have multiple and complex needs, including those experiencing homelessness, who live in supported residential settings, and are leaving prison.

Recommendation 14

Increase investment in recovery-oriented youth residential rehabilitation programs.

Recommendation 15

Facilitate improved integration of mental health and alcohol and drug services through increased funding, streamlined governance arrangements and a skilled and knowledgeable workforce, including peer workers.

Recommendation 16

Ensure victim support services are responsive to the needs of victims of crime who have a mental health issue.

Supporting families and carers

Recommendation 17

Increase investment in support for the people who care for and support people with mental ill health.

Improving social and economic participation

Recommendation 18

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

Developing this submission

Throughout cohealth there has been great interest in the Royal Commission into Victoria's Mental Health System, recognising the vital opportunity it presents to improve the mental health of Victorians. Staff, community advisors, clients and other members of our community have all been keen to contribute. In response to this interest cohealth has undertaken extensive consultation to develop this submission. A working group comprised of cohealth staff with expertise in mental health, both in mental health service provision and a range of other program areas, was formed to oversee the work. Conscious that mental health and illness touches everyone, we made particular efforts to gather the perspectives of those who are not specifically involved with mental health services, including cohealth community advisors, clients and members of our community.

Consultation occurred through:

- A cohealth survey sent to all staff, cohealth community advisors and members of our community.
- cohealth staff were encouraged to share the survey with their clients, and to assist them to complete it (where needed).
- Consultation with cohealth mental health program consumers and those who care for them.
- Consultation, individually and in groups, with staff with knowledge and practice experience in specific program areas.
- Participation in external consultations with partners and alliances.

cohealth acknowledges and appreciates the time and expertise contributed to developing to this submission.

cohealth recognises the critical value of the Royal Commission hearing directly the voices of people with experience of mental illness, and those with views about improving mental health. To this end we have also shared information on how to participate directly in the Royal Commission to clients, consumers, staff, partners and through social media.

Themes from our consultations:

> *'There are a whole bunch of seriously dedicated consumers and workers squirreling away on the ground to be flexible and to improve the mental health system'*
>
> cohealth worker

It is clear from our consultation responses that many existing aspects of the mental health system are appreciated by the community. In particular, services that reflect key guiding principles (outlined on p12) are held in high regard, such as:

- The knowledge and skills of community mental health workers working from a recovery-oriented, coaching approach. Peer workers are particularly deeply appreciated.
- That there are a range of supports available to provide appropriate responses:
    - to people at different stages of mental ill health and illness
    - to people at different life stages

    - to provide specialised responses to diverse groups eg young people, LGBTIQ communities, refugees, people who are homeless etc
    - outreach
    - specialised programs that work with people with multiple and complex needs
    - access to long term case coordination
    - community-based programs in particular are highly valued
- Housing programs that incorporate holistic, wrap around support.
- Programs that provide integrated and collaborative approaches, and continuity of care from clinical to community settings.
- Programs that support social inclusion and reduce isolation.
- The progress made in increased community awareness and understanding of mental illness, and the reducing stigma about it.
- Those that are based on, and foster, consumer leadership, participation and advocacy.

Nonetheless, the cohealth community also expressed deep concern about shortcomings of the mental health system, reflecting those expressed by other consumers, carers, workers, organisations and academics:

- Services are limited, meaning that people cannot receive care, support, treatment and other social supports, when they need it, or for as long as they need it. This occurs along the continuum from early intervention through to acute services and is deeply frustrating – and at times harmful - for consumers, those who care about them and workers. People are confronted with barriers such as:
    - long waiting times and lists
    - inaccessible location or restrictive geographic boundaries to services
    - services that people do not feel safe in for cultural or other reasons
    - lack of awareness about available services
    - poor integration of services
    - prohibitive costs.
- Similarly, even when consumers obtain support it may not be for sufficient duration.
- Changes to the service system – most recently the loss of Mental Health Community Support Services as the NDIS rolls out in Victoria – have been distressing for many people previously supported by these services.
- Difficulty of getting help early when mental health declines, rather having to wait until a crisis is occurring to receive care.
- Importance of having supports available in the community where people live, including outreach workers (and assertive outreach where needed).
- Importance of stable, affordable housing, with or without specific mental health supports.
- Complexity is not well dealt with. Mental ill health can occur in conjunction with other circumstances or conditions that contribute to vulnerability, such as alcohol and other drug use, experiences of homelessness, refugee and asylum seeker background, people with physical ill health or disability, intellectual disability or involvement in the justice system. Too often these experiences are addressed in isolation from each other.
- Various parts of the systems such as clinical mental health, community mental health, physical health, housing, alcohol and other drug services, carer support etc

are not well coordinated. People do not always know what services are available and they can be difficult to navigate. The removal of community-based mental health services brought by the NDIS roll out in Victoria have exacerbated this situation.

- Impact of isolation on mental health and participation in community and employment.
- The critical importance of a skilled and experienced workforce across all areas that intersect with people experiencing mental ill health. Consumers told us that not all workers focus on strengths, client values and recovery, People also identified a lack of workers from the diverse communities people live in, and the need for training for those in non-mental health specific roles. The limited number of peer workers across the system was also a concern.
- Many cohealth consumers and workers expressed concern about the shortcomings of the NDIS, particularly the gaps left by the loss of Mental Health Community Support Services. The loss of the psychosocial rehabilitation focus for people with serious mental illness, even for those eligible for the NDIS, is a grave concern for many.
- The ongoing need to improve mental health literacy across the community and to provide resources and training to assist with this.
- Continued stigma about mental illness, despite recent improvements, and the impact this has on people.

These shortcomings reflect, to a large degree, the lack of resourcing of mental health services, along the spectrum from prevention, early intervention and through to acute care, and are expanded on in more detail in the remainder of this submission.

Context

Almost half of Victorian adults will experience mental illness in their lifetime, with 3% of the population, or nearly 150,000 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] Indeed. mental illness is the single largest contributor to years lived in ill-health and is the third largest contributor (after cancer and cardiovascular conditions) to a reduction in the total years of healthy life for Australians.[3]

Various social, economic and physical environments – the social determinants of health – also interact to contribute to and compound the impact of mental illness.

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 carers, 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 they need to enable them to live contributing lives and participate as fully as possible as members of thriving communities[4] - regardless of their economic or social circumstances. Experiencing good mental health should not be determined by someone's cultural background, sexual identity, age, gender, employment status, disability, where they live, or by experiences of compounding disadvantage.[5]

In line with the National Mental Health Commission's *Contributing Life Framework*[6], 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

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[1] Mental Health Victoria 2018 *Saving lives. Saving money. The case for better investment in Victorian mental health.* https://www.mhvic.org.au/images/PDF/Policy/FINAL_Saving_Lives_Money_Brochure_HR.pdf

[2] Victoria's 10-Year Mental Health Plan 2015 https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-plan

[3] Australian Institute of Health and Welfare 2016. Impact and causes of illness and death in Australia 2011, Australian Burden of Disease Study series no. 3, Canberra. https://www.aihw.gov.au/reports/burden-of-disease/abds-impact-and-causes-of-illness-death-2011/contents/highlights

[4] http://mentalhealthcommission.gov.au/our-reports/our-national-report-cards/2014-contributing-lives-review.aspx

[5] Social Ventures Australia 2019 *SVA Perspectives: Mental Health* https://www.socialventures.com.au/assets/SVA-Perspective-Paper-Mental-Health.pdf

[6] http://mentalhealthcommission.gov.au/our-reports/our-national-report-cards/2014-contributing-lives-review.aspx

    - 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
- 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 'transinstitutional' 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 safe, 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.

First and foremost, the 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 and social and economic participation.

Other essential principles that should underpin all mental health responses include:

- 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

Recommendation 1:

The 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.

Recommendation 2:

All mental health responses be based on clear guiding principles, including 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 Royal Commission to specifically and separately consider 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.[7] The intergenerational impact of colonisation, trauma and marginalisation has been significant. Better outcomes for Aboriginal and Torres Strait Islander peoples requires recognising the impact of these cultural determinants of health, and the positive benefit of self-determination.

Aboriginal and Torres Strait Islander presence and leadership is required across all parts of the mental health system to ensure the best mental health outcomes for these communities.[8] Aboriginal community controlled organisations and peak bodies are central to self-determination and should play a central role in the design and provision of culturally safe services.

Recommendation 3:

Aboriginal and Torres Strait Islander leadership and presence is required across all parts of the mental health system.

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[7] NACCHO 2018 *Budget proposals to accelerate closing the gap in indigenous life expectancy* http://www.naccho.org.au/wp-content/uploads/NACCHO-Pre-budget-submisison-2018.pdf

[8] National Aboriginal and Torres Strait Islander Leadership in Mental Health 2015 *Gayaa Dhuwi (Proud Spirit) Declaration* https://natsilmh.org.au/sites/default/files/gayaa_dhuwi_declaration_A4.pdf

Social determinants of mental health[9]

'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[10]

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. As the World Health Organisation (WHO) identifies:

> 'A person's mental health and many common mental disorders are shaped by various social, economic, and physical environments operating at different stages of life. Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk. It is of major importance that action is taken to improve the conditions of everyday life, beginning before birth and progressing into early childhood, older childhood and adolescence, during family building and working ages, and through to older age'[11]

As the WHO explains, 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 Victorians, and the responses to those with mental ill health, it is essential that that Royal Commission gives careful consideration of these matters. Any reforms aimed at improving the mental health of Victorians, 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.

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[9] 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\

[10] Dr Friedli, L 2009 *Mental health, resilience and inequalities* WHO Europe http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf

[11] WHO 2014 *Social Determinants of Mental Health* https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf;jsessionid=4CEB07B5B5AC471969CBE3441CDCCD5A?sequence=1

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, social structures and policies that underpin society.

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, with the relationship between low economic status and elevated incidence and prevalence of mental illness now well recognised.[12] Studies throughout the world have demonstrated an inverse relationship between mental illness and social class[13] – that people on lower incomes have poorer mental health than those on higher incomes. Barriers to opportunities, such as lack of work and limited 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.[14]

   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 are not treated.[15]

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[12] Murali, V & Oyebode, F 2004 'Poverty, social inequality and mental health' Advances in Psychiatric Treatment, vol 10, 216-224 https://www.cambridge.org/core/services/aop-cambridge-core/content/view/39E6EB94B44818EDE417F181AC300DA4/S1355514600001322a.pdf/poverty_social_inequality_and_mental_health.pdf

[13] Murali, V & Oyebode, F 2004 'Poverty, social inequality and mental health' Advances in Psychiatric Treatment, vol 10, 216-224 https://www.cambridge.org/core/services/aop-cambridge-core/content/view/39E6EB94B44818EDE417F181AC300DA4/S1355514600001322a.pdf/poverty_social_inequality_and_mental_health.pdf

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

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

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.[16]

As such, addressing poverty is essential to improving mental health now and into the future. Creating secure jobs that are responsive to the specific needs of vulnerable job seekers (such as child care responsibilities and adaptations for those with disability or illness) will lift people out of poverty and improve their mental health.

At the same time, we need to challenge narratives that demonise people who are unemployed, and recognise that it is a lack of jobs, rather than a lack of willingness to work, that is the key barrier.

The accessibility of services to people on low incomes needs to be improved. Our dual public/private mental health system means that those with higher incomes are able to pay for services in the private system, while those without these resources have to wait for space in the public system. Barriers to accessing services created by co-payments, travel costs, child care needs, medication costs and lack of flexibility with appointments needed for people with casual and changing work hours all need to be addressed.

One of the key drivers of poverty is the appallingly low rate of Newstart Allowance. 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, marginalisation and poorer mental health. 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.[17] cohealth recognises that income support payment rates is a Federal government responsibility, nonetheless we believe it is such a critical issue to wellbeing that all levels of government and the Royal Commission should advocate strongly to the Federal government for an increase in the payment rate.

2. 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 materialism, for example, is associated with dissatisfaction, depression, anxiety and isolation.[18] The very social structure that we now live in has exacerbated levels of anxiety and depression.[19] As stress and insecurity play a significant role in mental ill health that it is not surprising

[16] SBS 2017 *How much do you know about the science of poverty?* 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

[17] Kiely, K & Butterworth, P 2014 'How has Welfare to Work reform affected the mental health of single parents in Australia?' Australian and New Zealand Journal of Public Health, vol 38, no 6 pp 594-595 https://onlinelibrary.wiley.com/doi/full/10.1111/1753-6405.12304

[18] Eckersley, R 2006 'Is modern Western culture a health hazard?' International Journal of Epidemiology, vol 35 pp 252-258 https://www.richardeckersley.com.au/attachments/IJEpi__culture_1.pdf

[19] Hari, J 2018 'Is neoliberalism making our depression and anxiety crisis worse?' In These Times https://inthesetimes.com/article/20930/depressed-anxious-blame-neoliberalism

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.

3. 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.'[20]

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.[21] 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.[22]

More broadly, systemic racism serves to maintain or exacerbate the unequal distribution of opportunity across ethnic groups through the way our systems and 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[23], and as socio-economic status declines, so does mental and physical health.

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[20] Department of Health and Human Services 2017, Racism in Victoria and what it means for the health of Victorians, State Government of Victoria, Melbourne. https://www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians/survey-data-and-reports/racism-in-victoria

[21] Ibid

[22] Ibid

[23] Ibid

4. Stigma and discrimination

Emerging evidence indicates that stigma and discrimination are also fundamental causes of health inequalities.[24] 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.

5. 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.[25] 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).[26]

We also now know how important stable housing is for children's development and wellbeing.

> 'Research continues to demonstrate the direct (cognitive, social, emotional, and biological outcomes) and indirect (parent's caregiving capacity) impact of physical environments on children's development. Negative home environments during the *first thousand days* have been linked to a host of developmental issues, including inferior language development; behaviour problems; insufficient school readiness; aggression, anxiety and depression; and impaired cognitive development.'[27]

[24] Hatzenbuehler, M, Phelan, J & Link, B 2013 'Stigma as a fundamental cause of population health inequalities' American Journal of Public Health Vol 103 (5) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3682466/
[25] http://www.nwhn.net.au/Health-Homelessness.aspx
[26] 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
[27] Strong Foundations collaboration 2019 *The first thousand days: A case for investment* https://www.aracy.org.au/documents/item/608

Other research has concluded that governments can improve the mental health of economically vulnerable populations through more supportive housing policies.[28] Despite our knowledge of the importance of stable, affordable housing, the current housing market has many well documented shortcomings – 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.[29] 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. A minimum of 3,000 new public and community housing dwellings over the next 10 years are needed, just to meet current demand.[30]

A lack of appropriate housing options can lead to acute services being faced with a difficult choice when discharging patients – do they discharge someone into homelessness or inappropriate housing, or keep an acute bed occupied by someone when it may not be clinically required. The number of Victorians who have exited mental health facilities into homelessness has grown by 65 per cent over the past five years.[31] At the same time, there are increasing accounts of people complex needs staying in acute settings for lengthy periods of time due to the lack of appropriate supported housing.[32]

6. Loneliness and isolation

The significant health impacts of loneliness and isolation are becoming increasingly well known. People who are socially isolated or lonely are at risk of premature mortality at rates comparable with other well-established risk factors, including lack of physical activity, obesity, substance abuse, poor mental health, injury and violence. The research literature also identifies relationships between loneliness and poor mental health, including depression, lower levels of self-worth, and subjective wellbeing.[33]

Our consultations with members of the cohealth community identified a deep sense of loss among people with mental illness about the closure of 'drop-in' services a number of years ago. They talked about the sense of safety they had within these services from being among people who 'get' them.

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[28] Bentley, R et al 2016 'Housing affordability, tenure and mental health in Australia and the United Kingdom: a comparative panel analysis' Housing Studies, Vol 31:2 pp 208-222 https://doi.org/10.1080/02673037.2015.1070796

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

[30] CHP 2018 *Victorian Homelessness Election Platform* https://chp.org.au/wp-content/uploads/2018/09/Victorian-Homelessness-Election-Platform-2018.pdf; https://vcoss.org.au/wp-content/uploads/2019/03/DF_Online.pdf

[31] CHP 2018 *Victorian Homelessness Election Platform* https://chp.org.au/wp-content/uploads/2018/09/Victorian-Homelessness-Election-Platform-2018.pdf

[32] Perkins, M 2019 '"We are drowning": Sam doesn't have a mental illness, yet he's living in a psych ward' The Age https://www.theage.com.au/national/victoria/we-are-drowning-sam-doesn-t-have-mental-illness-yet-he-s-living-in-a-psych-ward-20190306-p5128a.html

[33] Relationships Australia 2018 *Is Australia experiencing an epidemic of loneliness? Findings from 16 waves of the Household Income and Labour Dynamics Survey* https://www.relationships.org.au/what-we-do/research/an-epidemic-of-loneliness-2001-2017

Strategies and programs to prevent and overcome loneliness across our community are increasingly necessary. They need to recognise and respond to the specific needs of various groups, including cultural safety, to ensure they are accessible to those who most need them.

Recommendation 4

The Royal Commission specifically consider the social determinants of mental health and identify actions to address them, particularly through:

- **Reducing poverty and the impacts of low income**
- **Acting on racism, stigma and discrimination**
- **Increasing affordable and secure housing**

Responses to the Terms of Reference

The following comments on issues identified in the Terms of Reference reflect cohealth's experience providing health, mental health and social support services to diverse communities.

Mental health and wellbeing touches many, if not all, the programs cohealth provides. Our doctors, nurses, oral health and allied health programs, along with a diverse range of social support services - family violence, drug and alcohol, homelessness, Aboriginal and Torres Strait Islander health, refugee health, child and family services – and our community building and health promotion activities all work with people who experience mental health challenges.

A particular area of expertise has been the delivery of community-based mental health services, particularly to people with serious mental illness and/or 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.

1. Preventing mental ill health

Preventing mental ill health from developing in the first place must be a key goal of a reconfigured mental health system. This has enormous benefits for the health and wellbeing of individuals, their families and communities and will have significant long-term financial savings for Victoria. As is the case with the physical health system, the mental health system is currently skewed towards treating people when they become unwell, rather than keeping them healthy.

The foundation for prevention must lie in addressing the social determinants of health, outlined above, including poverty, housing, racism and discrimination and isolation. At the same time, specific approaches can be used to improve mental health at different stages across the life cycle, and that meet the needs of particular groups in the community.

Examples of cohealth programs working to promote mental health and wellbeing include:

1.1 Community building and social inclusion

Enhancing social inclusion and strengthening communities has significant mental health benefits.[34] As such, cohealth collaborates with various communities that can experience exclusion to develop a range of programs aiming to address racism and discrimination and increase employment and social inclusion.

[34] VicHealth 2005 *Social Inclusion as a determinant of mental health and wellbeing* https://www.vichealth.vic.gov.au/-/media/ProgramsandProjects/Publications/Attachments/Social_Inclusion_Final_Fact_sheet.pdf?la=en&hash=A4B9ACB5FDCE6470975B85CD0F041F84B8491A57

A key example of a cohealth community strengthening initiative is Arts Generator.

cohealth Arts Generator works in partnership with communities to unlock creative potential and build connections by producing high quality, cutting edge art and art experiences. We work with communities experiencing structural disadvantage in the western region and inner north of Melbourne, specialising in engaging with a range of African communities, in particular the South Sudanese community.

Arts Generator programs that work to enhance social inclusion include:

- *Benchmark* - a participatory arts and health program for young African Australians that involves a program of cultural outreach in public space and intensive arts projects with artist participants and established artist/facilitators. The Benchmark program creates opportunities for young people, particularly those who have come to Australia from war-torn countries, to use collective imagination to envisage positive futures.
- *Sisters and Brothers* – works with children aged 8-12 years to build empathy towards those who experience discrimination, emphasising commonality and diversity, and promoting dialogue around diversity, race-based discrimination and its harms. Sisters and Brothers does this through storytelling, collaborative song-writing, musical rhythms from diverse cultural traditions, and role-play.
- *Indigenous Art Programs* - intergenerational initiatives that focus on individual and family wellbeing and healing through arts projects in a range of media.

A key feature of Arts Generator programs is the training, mentoring and employment of young artists/arts workers from the diverse communities cohealth serves, and partnerships with local councils, community, health and educational organisations.

Recommendation 5

Increase investment in a range of culturally relevant community building programs to enhance social inclusion.

1.2 Supporting children's development

Ensuring children start life well lays the foundation for their development through life. The first 1,000 days of a child's life are now recognised as critical for their future physical and mental health. Approximately one third of families seen by cohealth's Family Services team are impacted by mental health. Parenting with mental health issues can be challenging and can have significant impacts on the child. Parents can struggle to provide the care and support children require if they are coping with their own challenges. This can lead to children developing their own problems in behaviour and mood which leads to ongoing issues.

As the Parenting Research Centre describes: 'Children are affected by their parents' mental health difficulties, which make it harder for parents to care for their children and can also affect their relationships with their children. When parents are experiencing high levels of psychological distress, the children's own mental health can be impacted, as is

their academic and social functioning. Parental mental illness can be a significant factor in child protection cases.'[35]

Unfortunately, our Family Services team are finding it increasingly difficult to obtain support for parents with mental health issues such as depression and anxiety and this can lead to the family support workers spending more time on mental health case management at the expense of parenting support. This is in a climate of rising demand for our services and increasing pressure to work with families for shorter periods of time in order to increase the number of families we can assist.

We know that that mental health difficulties can affect the parent/child relationship, attachment of infants and their parents and the ability of parents to 'tune in' to the infant or young child. This impacts the child's own mental health and can have long-term consequences in their development, ability to engage in education and even physical health outcomes.

Better support for parents living with mental health problems would have a direct positive impact on the lives of their children.

Recommendation 6

Increase investment in mental health services for parents both as an investment in their wellbeing and as a critical way to prevent future mental health issues for their children.

1.3 Raising awareness of mental health

Prevention requires understanding of mental health, mental illness, and addressing the stigma that is still associated with it. The social and cultural stigma that exists around mental health has been identified as the primary reason people experiencing mental ill-health do not seek help or access services.[36]

Supporting Minds is an example of a successful project led by Horn of African communities and codesigned with cohealth to improve mental health literacy, reduce stigma related to mental health issues and improve community access to services and supports. Through focus groups community members had the space to explore issues relating to mental health and identify approaches to improving understanding of mental health. The importance of activities that improve social inclusion and connectedness, including employment, and addressing stigma and discrimination was also identified.

Recommendation 7

Increase investment in programs that promote awareness of mental health and illness, and the services and supports available, using appropriate approaches for diverse communities.

[35] Parenting Research Centre 2018 *Research brief: Parent mental health* https://www.parentingrc.org.au/wp-content/uploads/Mental-Health-Research-Brief-Oct-2018.pdf
[36] Social Ventures Australia 2019 *SVA Perspectives: Mental Health* https://www.socialventures.com.au/assets/SVA-Perspective-Paper-Mental-Health.pdf

2. Improving mental health outcomes and access to services

'Although it could always use improvements, Victoria has historically had one of the most robust, recovery-based, consumer-focused and comprehensive community-based psycho-social support systems in the world. This came about through the dedication, advocacy and persistence of hundreds of consumers and staff over many years. With the introduction of NDIS and the erosion of community-based mental health, it feels like all the blood, sweat and tears have been for nothing … It's heart-breaking to witness the dismantling of such a vibrant and hard-fought for sector, without regard for the long-term impact it will have on vulnerable people with mental health issues and the community as a whole. NDIS does not fit comfortably within the mental health model and is inadequate and/or not accessible to many clients. If additional, ongoing resources aren't made available within the community mental health sector as well as at the acute and clinical end, to continue the recovery-based work achieved over the past decades, the resulting impact will be enormous. Homelessness, helplessness, isolation, an increase in addictive and destructive behaviours and crime events along with an enormous burden on emergency departments and inpatient units will almost inevitably be the result. We can still fix this - we just need the resources and commitment by the Victorian Government to prioritise it.'

cohealth worker

2.1 Community-based and managed mental health services

'[community mental health workers] have been so important to the level of recovery I've achieved'

cohealth mental health consumer

Providing mental health services and supports in the community, close to where people live, and integrating with other physical health and social supports services is acknowledged as the most effective approach to intervening early to keep people well, engaged with their community and out of hospital.[37] 'Consistently, studies show that people living with mental illness who are provided with well-planned, comprehensive support in the community have a better quality of life, develop an improved level of functioning and social contact, and have fewer relapses.'[38]

However, while there has been an increase in investment in primary mental health care in recent years, principally through the Better Access initiative (providing Medicare rebated psychological services), it is widely recognised that there is a gap in services between GP surgeries and hospital emergency departments, a situation characterised as the 'missing middle'.[39]

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[37] Victoria's 10-Year Mental Health Plan 2015 https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorias-10-year-mental-health-plan

[38] *Mental Health Coordinating Council 2007 Social inclusion: Its importance to mental health* https://www.mhcc.org.au/wp-content/uploads/2018/05/mhcc-social-inclusion.pdf

[39] Rosenberg, S 2015 'From asylums to GP clinics: the missing middle in mental health care' *The Conversation* http://theconversation.com/from-asylums-to-gp-clinics-the-missing-middle-in-mental-health-care-46345

Members of the cohealth community have described the challenges people with more serious mental health issues face accessing services to support recovery when they need them. Too often they describe not being able to access support until they experience a crisis, and that once this crisis has been dealt with, they feel they are back on their own again.

'You have to wait for a crisis to get attention rather than getting help when you first need it. Mental health should be treated like cancer. If you had cancer, they wouldn't wait until you were really unwell. You'd get treated early when it's first needed, not waiting until you're really sick'

cohealth consumer

Mental health funding and governance arrangements need to be re-oriented towards keeping people well and out of hospital. This requires significant investment in community-based care models that work from a recovery-oriented approach, outreach to consumers, have a significant peer workforce, and are based on the key principles previously outlined. These models need to be integrated with physical health and social support services, such as housing, alcohol and drug, justice, family support, family violence and employment.

cohealth believes that community health services provide an ideal platform – and model – for this work. Community health services have an extensive and successful history of providing 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.

2.2 Integrated service responses

A common complaint from members of the cohealth community is that services are not sufficiently integrated. Too often there is inadequate continuity of care across the various components of mental health care – primary care, community-based care, clinical services, residential and inpatient care. Likewise, mental health services are not well co-ordinated with physical health and social support services. Without holistic, integrated services that can intervene early mental health gains can be slower, or jeopardised.

This is particularly critical for people with multiple and complex needs, who without support may not know of, or receive, appropriate supports in a consistent and coordinated way. cohealth's Indigo program is a specialist program providing assessment and care plan coordination for clients with multiple and complex needs. Indigo is a multidisciplinary team that has extensive knowledge of specialist and mainstream services that can be accessed to reduce the risk and barriers for clients who require multiple services to ensure services work cohesively together.

Members of the Indigo team have identified a number of barriers to clients being able to successfully address their issues including: a lack of resources, including funding; the risk

adversity of services; constraints on information sharing; and the complexity of service access. Key features of the Indigo service model designed to overcome these barriers include: engaging appropriate care team members; having access to professionals and immediate supports who have knowledge and experience relevant to the client's needs; regular and facilitated communication with care team members across services; and the ability to share client information to ensure continuity of care.

The need for integrated and coordinated mental health, physical health, and social support services is recognised in key planning documents, such as *Victoria's 10-Year Mental Health Plan* and the *Fifth National Mental Health and Suicide Prevention Plan*. As *Victoria's 10-Year Mental Health Plan* states: 'Access to services is a priority and should be easy for individuals and their families and carers. Services should have good linkage, communication flow, coordination and integration. People should be linked to the right services at the right time and their journey through these services should be safe, seamless and make sense'.[40]

Despite this, inadequate integration and continuity of care continues to be identified as a major barrier to effective mental health care. Integrated approaches require resourcing to enable services to work together, but too often funding is not sufficient to allow this. Increased investment that enables integration and collaboration is critical and will have the significant benefits of greater wellbeing and participation, reduced need for acute services and reduce financial costs.

2.2.1 Advance Statements and nominated persons

Advance Statements and Nominated Persons were introduced as part of the Mental Health Act 2014. Advance Statements are documents that record a person's treatment preferences in case they become unwell and require compulsory mental health treatment decisions. A Nominated Person can be identified by a person with mental illness to receive information and provide support while they are receiving compulsory mental health treatment. In the event of compulsory mental health treatment, psychiatrists must have regard for people's treatment preferences, including those set out in an Advance Statement and communicated by Nominated Persons.

cohealth consumers identified that there is insufficient knowledge in the community about the use of Advance Statements and Nominated Persons. This is supported by the very low uptake of both, with only 2 to 3 per cent of people who experience compulsory treatment having an Advance Statement, and even fewer a Nominated Person.[41] Advance Statements have the potential to improve the quality of care, treatment and support people receive, and in doing so, support their recovery.[42] Improving the uptake of Advance Statements and Nominated Persons will provide benefits both for people with mental illness and those who support them.

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[40] Victoria's 10-Year Mental Health Plan 2015 https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-plan

[41] cohealth 2019 *Community Mental Health Evaluation Report: Defining a role for cohealth in Advance Statements and Nominated Persons* (unpublished internal document)

[42] Maylea, C; Jorgensen, A; Matta, S; Ogilvie, K; Wallin, P. 2018 'Consumers' Experiences of Mental Health Advance Statements' Laws 7, 22. https://doi.org/10.3390/laws7020022

2.3 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 psychosocial rehabilitation supports have been significantly reduced in Victoria in recent years.[43] Specifically, Victorian state funding for community managed mental health services has been transferred to the NDIS as part of NDIS funding arrangements.[44] Victoria is the only state where this has occurred. As a result, Mental Health Community Support Services (MHCSS) are 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'.[45]

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 Victorian and federal 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[46], and allows for ongoing oversight of their condition.

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

[43] 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.
[44] Mental Health Community Support Service (MCHSS) funding
[45] Knaus, C 2018 'Fears those with severe mental health issues are falling through NDIS cracks' The Guardian https://www.theguardian.com/australia-news/2018/jan/17/almost-75-of-people-on-mental-health-programs-left-without-ndis-support
[46] Slade M, McDaid D, Shepherd G, Williams S, Repper J 2017 *Recovery: the business case* ImROC https://imroc.org/resources/14-recovery-business-case/

hallmark of psychiatric rehabilitation'[47], 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. As mentioned earlier, cohealth believes that Victorian community health services provide an ideal platform – and model – for this work.

2.4 Physical health

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*[48] 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

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

[48] National Mental Health Commission 2015 *Equally Well Consensus Statement: Improving the physical health and wellbeing of people living with mental illness in Australia* https://www.equallywell.org.au/wp-content/uploads/2018/12/Equally-Well-National-Consensus-Booklet-47537.pdf

alcohol and drug, family violence, child and family services, Aboriginal and Torres Strait Islander and refugee 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 require 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.

2.5 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 (p 38) and 2 (45)* both illustrate this approach well.

Our consultations indicated that there have been welcome improvements in the knowledge of mental health among a range of health and social support providers. The knowledge and skills of the community mental health workforce, capable of a range of mental health interventions and able to help people avoid the need for hospitalisation, are highly regarded.

At the same time there is deep concern about the loss of this skilled workforce – and the support they provide - as Mental Health Community Support Services close. As a mental health worker described:

> *'The roll in of all community mental health service funding into the NDIS means that the casualisation and de-skilling of the workforce with the pay reduction means clients with mental health issues would have workers who may not have the understanding of mental health or have any training in suicide prevention strategies and strategies to manage complex mental health presentations.'*

Other issues raised in our consultations included the need for:

- A more diverse workforce to better reflect and meet the needs of diverse communities

- Training for workers in other health, social support and emergency services on recognising and responding to mental illness, along with opportunities for supervision, support and debriefing
- The consistent use of strength-based and client centred approaches. Consumers felt that clinical inpatient services were not always achieving this.
- Increased use of trauma informed lens when responding to mental ill health
- Training on meeting the specific needs of various groups, such as those with multiple and complex needs, children, young people and culturally diverse communities
- Expanded peer workforce
- Training in working with families

Peer workforce

> *'I wish I'd had a peer worker when I was a teenager. I could have saved many years of my life.'*
>
> cohealth worker

Expanding and developing the peer workforce is key to enhancing the 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.[49] *Lived Experience account 2* (p45) 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 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*

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

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[50]; 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.

2.6 Funding and governance

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 previously mentioned, 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 these 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:

- Consumer wellbeing must be at the foundation of funding and governance arrangements. Funding models should have inbuilt opportunities for consumer led adaptation and innovation to ensure they are responsive to the changing needs of consumers.
- 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

[50] 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.

for family services to address these same issues.[51] 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.
- There be recognition that consumer directed care models of funding do not work for all people, particularly those with psychosocial disability, complex needs or who experience marginalisation. Consumer directed funding models to date have not adequately provided for the additional costs of delivering services to these groups (such as interpreting, assertive outreach, travel and longer appointments). Alternative funding arrangements, such as block funding, should continue to ensure the needs of these people can be met.
- Providing effective services needs a skilled workforce and integrated services. Funding needs to include adequate provision for professional development, supervision, support and debriefing, and to resource effective collaboration between services.
- 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 8

Invest significantly in community-based early intervention and support services to shift the orientation of the mental health system towards keeping people well and reducing the need for acute care. This needs to include significant re-investment in community-based psychosocial rehabilitation, based on recovery-oriented practice, for those who need it. Community health services provide an ideal platform to provide these services.

Recommendation 9

Mental health care should be integrated with multidisciplinary physical health care and social support services, and based in the community where people live, where possible. Integration must be supported with adequate funding to enable collaborative care, streamlined information sharing processes and increased uptake of Advance Statements and Nominated Persons.

Recommendation 10

Develop the mental health knowledge of the workforce including through increasing the peer workforce and enhancing the education and awareness of health care practitioners about mental health, including the physical health needs of people with mental illness.

[51] Productivity Commission 2017 Introducing competition and informed user choice into human services: Reforms to human services. Inquiry report. https://www.pc.gov.au/inquiries/completed/human-services/reforms/report

Recommendation 11

Governance arrangements need to ensure that outcomes and continuity of care are central priorities. Investment in robust impact and outcome measurement and evaluation is required, as is funding periods that are of sufficient duration to enable cycles of program development, evaluation and improvement.

3. Responding to the needs of specific groups

Critical to the success of all programs and supports aimed at promoting mental wellbeing, recovery and clinical care is that they are oriented to the diverse needs of communities. If not, barriers such a cost, location of services, and cultural appropriateness will prevent their use, particularly by people experiencing disadvantage.

cohealth has extensive experience working with diverse communities and developing programs with these communities to best respond to their needs. In particular, we prioritise those communities who experience disadvantage and marginalisation, and hence are at greater risk of both developing mental health conditions, and of finding that services may not be appropriate to their needs and circumstances.

3.1 Aboriginal and Torres Strait Islander people

Members of cohealth's Aboriginal and Torres Strait Islander community, including community members and workers, have identified the critical importance of services that are culturally safe. Cultural safety can be defined as 'an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need.'[52]

This includes the need for more Aboriginal and Torres Strait Islander programs, workers, mentors and advocates; more involvement of, and support for, family in care; programs that recognise and build on strong community connections; and embrace the value of arts and creative therapies in supporting trauma healing. Trauma experiences are too often diagnosed, and treated, as a mental health condition in mainstream services, ignoring the deep intergenerational impact of colonisation, dispossession and the stolen generation.

In addition to employing Aboriginal and Torres Strait Islander health workers, cohealth programs that aim to improve mental health and wellbeing include:

- Footprints for Success. In conjunction with VACCA (the Victorian Aboriginal Childcare Agency) and Moondani Balluk (Victoria University), this program recognises the critical importance of the early years of a child's life for their future health and wellbeing. Footprints to Success focuses on addressing the health and wellbeing service gaps and access inequalities affecting Aboriginal and Torres Strait Islander children living in Brimbank, Maribyrnong and Wyndham.[53] Footprints' Aboriginal Key Support Workers assist families and their children to navigate the health and early years system with confidence and supports organisations to remove barriers to access and provide flexible and culturally safe services. Funding for this program is currently uncertain, despite its value to the community.

[52] Williams, R 'Cultural Safety – What does it mean for our work practice?' https://www.researchgate.net/publication/12967462_Cultural_safety_-_What_does_it_mean_for_our_work_practice

[53] DHHS 2018 *West News Connecting and partnering with Aboriginal communities* https://www2.health.vic.gov.au/-/media/health/files/collections/factsheets/w/west-news-issue-2.pdf

- Billabong BBQ - a weekly BBQ for Aboriginal and Torres Strait Islander people to get together and connect with the mob. While sharing healthy food community members can connect with a range of community services in one place.

3.2 People experiencing homelessness

The relationship between mental ill health and homeless works in two directions - the experience of homelessness can exacerbate existing mental illness and can also precipitate the deterioration of mental health. Homelessness has well recognised negative impacts on physical and mental health, including depression and other mental health problems.[54] 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).[55]

Disturbingly, the Council to Homeless Persons Victoria report a 65 per cent increase over the past five years of Victorians being discharged from mental health facilities into homelessness.[56] In addition to the hardships inherent with homelessness, follow up care and ongoing treatment for mental ill health is significantly harder. People with complex needs, such as mental illness, substance use, disability and a history of trauma too often cycle between homelessness and tertiary services such as emergency departments, acute mental health care and justice systems. At times they may stay longer in hospital than clinically needed, rather than be discharged into homelessness. The Council to Homeless Persons identifies an effective model that addresses both housing and the support to gain and sustain that housing – an approach known as Housing First or permanent supported housing.[57]

To respond to the needs of people experiencing homelessness, including those who experience mental illness, cohealth has developed a range of responses. Key to responding effectively is basing responses on the guiding principles outlined earlier – including using a person centred, trauma informed, recovery-oriented 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

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

[55] 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

[56] CHP 2018 *Victorian Homelessness Election Platform* https://chp.org.au/wp-content/uploads/2018/09/Victorian-Homelessness-Election-Platform-2018.pdf

[57] CHP *Ending chronic homelessness: A permanent supportive housing solution* http://chp.org.au/wp-content/uploads/2017/07/170707-permanent-supportive-housing-FINAL-1.pdf

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 per cent of clients who were placed in stable housing have maintained it long term; 46 per cent were linked to a GP where they previously weren't; and there was a 42 per cent 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.

3.3 Refugees and asylum seekers

People from refugee backgrounds face specific physical and mental health needs. Experiences such as the disruption of basic services, poverty, food insecurity, poor living conditions and prolonged uncertainty along with human rights violations, trauma or torture place them at increased risk of complex physical and mental health conditions. In addition to pre-arrival experiences, people from refugee backgrounds face numerous barriers to accessing health care after arrival in Australia. Isolation, lack of housing and meaningful employment and experiences of racism and discrimination are some of the experiences that can precipitate mental health issues or compound existing ones.

Addressing these stressors requires engagement with refugee background communities, greater understanding of the ongoing settlement stressors and co-design strategies to address these.

It is critical that mental health services for people of refugee backgrounds are culturally safe and accessible. Services need to be community-based, have a workforce trained in working with these communities, particularly employing workers from various refugee background communities. Integrated services, such as those provided by community health, provide the opportunity for holistic support and streamlined referral between health and social support providers.

The cohealth Refugee Asylum Seeker Health Program (RASHP) supports the health and wellbeing of people of refugee and asylum seeker background with a particular focus on those accessing services in the cities of Maribyrnong, Brimbank, Hume, Moonee Valley and Yarra. Delivered by a team of refugee health nursers, coordination support workers, counsellors, women's health nurses, physiotherapists and people working in community engagement, the program focuses on health assessment and monitoring, care co-ordination, capacity building, advocacy, education and the provision of person-centred culturally responsive health services. Individual mental health is monitored from the initial contact of each client until the client is referred to other services inside or outside cohealth.

A key feature of the RASHP is the employment of Bicultural Community Health Educators who work as a 'cultural bridge'. They facilitate capacity building workshops within their communities on a range of health and mental health issues and are also available to provide training to programs within cohealth to ensure services are culturally appropriate, accessible and effective.

3.4 People involved in the 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 previously outlined, 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 1

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*

3.5 Young people

As the majority of mental ill-health develops in adolescence, prioritising interventions for young people is critical. These services need to respond to the particular needs – developmental, social, educational and employment – of young people. For young people who need time to recover from mental illness cohealth runs several Youth Residential Rehabilitation programs supporting young people aged 16-25 with mental health issues in a safe residential setting. Using a holistic, recovery-oriented approach, these services enable participants to discover their strengths, learn or re-learn the skills and confidence for independent learning, manage mental illness and achieve recovery goals. This can include building better relationships and social connections; getting involved in sport and recreation; overcoming alcohol and drug issues; exploring education, training and work options; and finding permanent housing.

In our consultations with cohealth consumers, workers and community, the Youth Residential Rehabilitation (YRR) programs were regularly identified as exemplars of providing collaborative, holistic approach to recovery. The positive outcomes achieved by young people are attributed to the YRR approach: client directed, recovery and whole of health orientation; skill development towards independence; and the stability provided by being able to stay for 12 months.

Despite their success, there are insufficient youth residential rehabilitation programs across the state to meet demand.

3.6 LGBTIQ communities

cohealth is a signatory to the joint statement on LGBTI mental health[58], produced by Thorne Harbour Health, Rainbow Health Victoria, and Switchboard Victoria recognising that all lesbian, gay, bisexual, trans and gender diverse and intersex (LGBTI) Australians deserve to live happy and healthy lives, and to enjoy the benefits of a mental health system that is safe, affirming and supportive.

Studies have identified a range of barriers for LGBTI people accessing mental health services, including experiences of stigma and discrimination. More needs to be done to create safe and affirmative service pathways.

The joint statement calls for:

- The complete de-pathologisation of people with diverse sexual orientations, gender identities and sex characteristics.
- The protection and promotion of human rights of LGBTI people, including the right to bodily integrity and autonomy for trans and gender diverse and intersex people.
- Greater government investment in more general and specialist community controlled and mainstream LGBTI mental health services.
- Specialist family services to support people coming out or transitioning and their families.

[58] https://thorneharbour.org/news-events/news/leading-health-organisations-call-on-the-royal-commission-into-victorias-mental-health-system-to-consider-lgbti-mental-health/

- A comprehensive review of date gathering infrastructure, including coronial data, to better capture rates of mental health outcomes and suicide in LGBTI communities.
- Greater inclusion and safety of LGBTI people within the general mental health system, supported by organisational accreditation and whole-of-workforce training.

3.7 People who use alcohol and other drugs

There is a complex relationship between mental health and alcohol and other drug (AOD) use. AOD use can contribute to mental illness, along with a range of other health conditions; conversely people with mental illness may use alcohol and drugs as a means to cope with their condition or symptoms.[59]

Despite this, the integration of AOD and mental health services is not always as effective as it could be. While siloed funding and governance arrangements are a key contributor to this situation, services are acutely aware of the need for coordinated and integrated approaches to co-occurring mental health issues and alcohol and other drug use. Inadequate funding is a key constraint on the ability of services to work in a coordinated manner.

Recognising the particular health needs of people who use alcohol and other drugs, cohealth operates two Specialised Alcohol and other drug Primary Health Services (SAPHs). These services provide needle and syringe exchange, pharmacotherapy (Opiate Replacement Therapy, such as methadone), onsite monitoring and, where required, assistance to drug affected people and a co-located Hepatitis C clinic. Critically, clinical services, including GPs, nurses and allied health providers address immediate and long-term health issues, including significant holistic support to people with mental health issues.

Many users of our SAPHs report a history of trauma from early childhood neglect, physical and sexual abuse and limited education and many have undergone prison sentences related to drug use. Acknowledging the relationship with past events, trauma and drug use, and their connection with mental ill health and providing a safe place to examine these, is the first step along the path to recovery.

3.8 People living in Supported Residential Services

When large institutions for people with mental illness were closed from the 1960s (known as 'deinstitutionalisation') it was envisaged that a significant investment would be made in community-based services to support them and enhance their integration into the community. While there is no doubt that deinstitutionalisation has had many positive outcomes, some services previously provided were overlooked and insufficiently funded, housing in particular.[60]

[59] AIHW 2018 Alcohol, tobacco & other drugs in Australia https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/people-with-mental-health-conditions

[60] Drake, G 2014 'The Transinstitutionalisation of People Living in Licensed Boarding Houses in Sydney' Australian Social Work, 67:2, 240-255, https://www.tandfonline.com/doi/abs/10.1080/0312407X.2013.843714

As a result, a number of people with disability and people with mental illness ended up in alternate institutions particularly Supported Residential Services (SRSs), boarding houses and correctional facilities, a process known as 'transinstitutionalisation'. While 'these accommodation models were generally located "in the community", the practices and cultures of large institutions were present including congregate care, regimentation, and material deprivation'.[61]

People living in SRSs experience high rates of psychosocial disability and complex needs and have poor physical and mental health. They experience little choice and control over their lives, evidenced by extremely low levels of service engagement and community participation and minimal levels of connection with family or friends.[62] Despite this, the specific needs of people living in these facilities are often overlooked.

3.9 Victims of crime

cohealth operates a Victims Assistance Program in the western suburbs of Melbourne, helping victims and witnesses manage and recover from the effects of crimes including assault, sexual assault family violence and homicide. Services are tailored to individual needs and can including emotional support and practical assistance, counselling, dealing with the criminal justice system and links to other services including counselling and legal advice.

Workers in this program have observed an increase in the number of people presenting with complex mental health issues who have experienced a crime. However, victims services are not adequately resourced to most effectively support these people successfully navigate the criminal justice system as a victim. Proposals to improve responses for victims of crime who have a mental health issue include:

- Creating specialised roles to support victims of crime who have a mental health condition to successfully navigate the criminal justice system.
- Develop partnerships between victims services and mental health services.
- Develop a framework for increasing the knowledge and understanding of police about mental health issues to enhance support of victims of crime with mental health issues.
- Create a mental health specific position at each police station. Victims of crime with a complex mental health condition may have difficulties clearly articulating the details of a crime committed against them. Such a role could support the victim to be heard, and support police and victim services to achieve the best outcome for the client.

[61] Drake, G 2014 'The Transinstitutionalisation of People Living in Licensed Boarding Houses in Sydney' Australian Social Work, 67:2, 240-255, https://www.tandfonline.com/doi/abs/10.1080/0312407X.2013.843714
[62] Dearn L 2017 'Choice and control in supported residential services: the experience of people with psychosocial disability during the NDIS', research proposal (unpublished), RMIT

Recommendation 12

Ensure all services are culturally safe and reflect and respond to the specific needs of diverse communities through: supporting community and consumer led services; employing workers from these communities; ensuring services recognise the complex experiences that contribute to mental ill health; and ensuring mainstream services are culturally safe through training and employment practices.

Recommendation 13

Increase investment in holistic wrap around services to support people who have multiple and complex needs, including those experiencing homelessness, who live in supported residential services, and are leaving prison.

Recommendation 14

Increase investment in recovery-oriented youth residential rehabilitation programs.

Recommendation 15

Facilitate improved integration of mental health and alcohol and drug services through increased funding, streamlined governance arrangements and a skilled and knowledgeable workforce, including peer workers.

Recommendation 16

Ensure victim support services are responsive to the needs of victims of crime who have a mental health issue.

4. Supporting families and carers

'There is too much reliance and expectations within the mental health system on carers ability to manage clients putting significant emotional strain on carers, therefore there needs to be more recognition of carers own mental health and support.'

carer of person with mental illness

Unpaid care work is a critical part of the support provided to people with mental illness that often goes unrecognised. However, caring responsibilities can impact on 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.

A sense of exhaustion was common among responses from those who care for and support someone with a mental illness. They described how the lack of services mean they shoulder more of the care for their loved one, and that there is a lack of specific supports for them as carers. A range of issues and challenges were identified, including:

- Need for support – both in their caring role and in other areas of their life.
- More respite care or other supported accommodation to enable families to have a break from caring responsibilities.
- A desire for greater involvement of families and carers in plans regarding treatment and care. This includes viewing carers as partners in care and for them to be better informed by acute mental health services in planning and discharge conversations related to adult children.
- Need for other systems to recognise the demands of caring and make appropriate accommodations.
- Increasing demands on carers with closure of Mental Health Community Support Services as the NDIS rolls out.
- Distress to families when the police respond to crisis situations, particularly if help had been sought but not received from acute mental health services.
- Discharging people who have had a serious crisis, such as a suicide attempt, after a brief period of time has significant emotional and psychological impacts on carers.
- The particular needs of young carers. As a cohealth worker states 'I have often thought that the children of mental health [service] users - and youth carers in particular - are asked to shoulder responsibilities that no child should have to bear. It's too easy to hand responsibility over to young (and often isolated) family members - we can do better.'

'In ATSI families, a family issue has to be addressed first before individual health issues can be managed'

cohealth Aboriginal and Torres Strait Islander worker.

cohealth Aboriginal and Torres Strait Islander workers and community members in particular talked about the importance of involving and supporting families and carers more in the care of people with mental health issues.

Recommendation 17

Increase investment in support for the people who care for and support people with mental ill health.

5. Improving social and economic participation

Programs in areas as diverse as the arts, music, cultural activities and sports aim to improve social inclusion. cohealth facilitates a range of successful activities and programs, tailored for the needs and interests of particular groups that face barriers to social participation. In addition to the Arts Generator and Youth Residential Rehabilitation programs described earlier, 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.
- 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 previously outlined. 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.

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

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 2

A friend of mine, a bit over two years ago now recommended me to apply to PHAMS [Personal Helpers and Mentors]. 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.

Volunteering

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 has had to close in mid-2019 as funding ceased.

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*

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*

Recommendation 18

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