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Submission to the:

Productivity Commission Inquiry into
“The Social and economic benefits of
improving mental health”.

April 2019

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About Anglicare Australia

Anglicare Australia is a unique national network of over 35 independent, for purpose community service organisations, all with links to the Anglican Church. Through our services and advocacy, the Anglicare Australia Network partners with people, families and communities to build resilience, inclusion and justice.

With a workforce of close to 20,000 staff and 9,000 volunteers, the Anglicare Australia Network contributes to more than 50 service areas in the Australian community. Our services reach more than 1.3 million people with direct service delivery to nearly 500,000 clients in partnership with them, the communities in which they live, and other like-minded organisations in those areas. In all, 1 in every 20 Australians access Anglicare services throughout the year.

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Contents

About Anglicare Australia.....	1
Contact Person	2
Chapter 1 - Introduction	5
Chapter 2 - How we live and work, and mental health	7
The value of a secure and liveable income is measured in our wellbeing.....	7
Supporting participation in society, and examining how we work	8
The importance of a home.....	9
The impact of our environment on our wellbeing.....	9
Fostering social connection	11
Recommendations.....	11
Chapter 3 - Community-based services.....	13
Case Studies Series 1 – Early intervention	14
From Anglicare NT – headspace Darwin Prism Group	14
From Anglicare SA – culturally sensitive care to live beyond suicide	15
Case study series 2 –The power of holistic case-management to deal with crisis and complexity	15
From Anglicare Central Queensland – two client case studies	16
From Anglicare SA – two case studies.....	18
Case study series 3 – meeting the needs for particular vulnerable groups.....	20
Connect for Life Carer Support Services	20
headspace Pilbara.....	20
Yes! Housing	22
Recommendations.....	24
Chapter 4 - System interfaces	25
Income support	25
Recommendations.....	26
Housing and homelessness	26
Flexible, integrated, person-centred support services and housing options.....	26
Case study 1 – Anglicare South Queensland’s Homeless Services Women and Families (HSWF)	27
Case Study 2 – Anglicare WA’s Foyer Oxford Youth Accommodation Services	29
Supports to transition into sustainable community living	30
Building capacity in the community to enable support, dignity and inclusion	30
Recommendations.....	32

Skills acquisition, employment and healthy workplaces	32
Education and Training	32
Government support to find and maintain a job.....	33
Mentally healthy workplaces	37
Recommendations.....	39
Health.....	39
Rural and remote services.....	40
Recommendations.....	43
Justice and child safety	44
Young people and the justice system, and mental health	45
Addressing family functioning and skills	46
Therapeutic trauma informed intervention and care for children and young people	49
Young people, mental illness and justice settings	50
Holistic Procurement approach	50
Recommendations.....	50
Community mental health and psychosocial support services.....	51
Eligibility and access to the NDIS	51
Inadequate continuity of support.....	54
Improvements needed in NDIS model for psychosocial disability	55
Increased risk of homelessness for people with complex needs	55
Carers missing out under NDIS	56
Recommendations.....	57
Aged Care	57
Conclusion.....	57
References.....	58

Chapter 1 - Introduction

Anglicare Australia is pleased to respond to the Commission's extensive and thorough issues paper on the Social and Economic Benefits of Improving Mental Health. We hope to also contribute more to this important inquiry's later stages.

This submission draws extensively on the insight of our members, and our discussion below sews together a number of stories and case studies that throw a light on the issue and opportunities we explore. Recognising the importance of this inquiry, several of our members have also made separate submissions - The Samaritans, Anglicare NT, Anglicare Sydney, Anglicare Victoria and The Brotherhood of St Laurence – and we commend them to you.

The Commission's issues paper contains two contradictory approaches to this inquiry: one is a strengths-based approach; the other focuses on the cost and burden of people with mental illness. On page 1 the Commission starts with a strengths-based approach, stating that: *"this inquiry will essentially be asking how people can be enabled to reach their potential in life, have purpose and meaning, and contribute to the lives of others. That is good for individuals and for the whole community."* Then not far on exploration of the issues begins with a summary of the breadth and depth of mental illness in Australia, which identifies the costs associated with mental illness in economic and limited social terms. Later on again, the Commission states that it wants to consider the mental wellbeing of all Australians; yet the vast majority of the paper then focuses on how various services do or do not support people who are already mentally ill. This is a second contradiction which pits a universal approach against targeting specific populations. These contradictions in how to approach this inquiry needs to be resolved.

Anglicare Australia recommends the Commission resolves these tensions by approaching its draft paper as a strengths-based envisaging of a mentally well society with a universal system of mental health services. We know that the key supports for maintaining mental wellbeing are love and care and social connection; being active; sufficient space to be mindful and present in life; learning and purpose; and reciprocity¹. Such an approach is embedded in the National Framework for Recovery-Oriented Mental Health Services, which articulates an objective for all people as *'...being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues.'*² Underlying these are the bedrock structures, that is social determinants, that support our overall wellbeing –secure and appropriate housing; good nutrition and health; sufficient income; and access to meaningful work and learning³.

These factors are physical and policy-based structural settings, the presence or absence of which, and how they interact, affect us all. Starting from a structural understanding stops us from seeing people with mental illness as problems to be solved in isolation; and instead focuses us on how to build mentally healthy and resilient communities, and embed mental health services within them.

Chapter 2 of our submission covers core issues regarding social determinants of health and broader environmental factors we believe the Commission must pay attention to in answering its intention of considering the mental wellbeing of all Australians. We have particularly focused on those large domains for which our governments are responsible and where changing circumstances are, at a population level, helping or compromising our mental wellbeing and health.

We therefore also strongly caution against the Commission's seeming intention to focus on the mental health needs of particular population groups as listed in the issues paper. We contend that we must first envisage and build a mental health system with the capacity to serve the needs of all Australians, and then look to address the particular additional barriers to access, or additional needs of specific groups, to ensure equity of access and culturally appropriate care. This is essential because focussing only on the needs of particular groups experiencing high rates of mental illness would miss the blunt fact that the system of support is woefully inadequate for people in every section of our society, and work against the accepted approaches to ensuring early detection and intervention. Universal services are much easier to approach, less likely to attract stigma, and at lower risk of fading out of sight and dwindling over time.

Anglicare Australia Network members deliver community-based mental health services and many other community services, grounded in a strong understanding of how social determinants impact on people's mental health, and centred on the person's particular needs and circumstances, to provide holistic and integrated assistance. In our experience, community-based mental health services are best placed to assist people along the spectrum of the experience of mental illness - from prevention and early detection, to varying levels of intervention including at crisis stage. We focus in this submission on demonstrating the success of community-based approaches built on these principles, and hence why they should be the cornerstone of our mental health system, in chapter 3.

Chapter 4 examines core government services and how they function - or not - for people who are mentally ill, and interface with other systems people with mental illness often access.

We recommend the Commission add to its assessment approach:

- An overarching conception of the core elements of a mentally healthy and resilient society, so that it can benchmark more appropriately.
- Recognition of the importance of the social determinants of health in that conception, to better understand the environmental settings and other structural precursors to mental well-being and mental illness.
- Includes substance use disorders including gambling addictions, as there is considerable comorbidity between addictions and mental illness. The work of Anglicare Tasmania's Social Action and Research Centre on gambling addiction⁴ makes the case clearly for the need to consider this cohort in terms of mental health services due to comorbidities and the risk of suicide. Similarly, the separate submission to this inquiry from our member agency The Samaritans shows that people with a dual diagnosis of substance addiction and mental illness are a cohort not receiving sufficient appropriate services⁵.

Recommendations are offered throughout the document.

Please note that all personal case studies provided in our submission have been de-identified through name changes and other potentially identifiable details removed to protect client privacy. They have also been written by individual case workers, hence the variation in styles.

Chapter 2 - How we live and work, and mental health

Anglicare Australia commends the issues paper's statement that the focus of this inquiry will be on the mental wellbeing of all Australians, rather than an atomised approach beginning with those living with mental illness.

In response, we draw the Commission's attention to the fundamental importance of the social determinants of health to our mental health. The issues paper reflects this in part, with the interest in homelessness, income support, and employment support. However it focuses on these from the view of how the government services involved respond to people with mental illness in these areas; rather than starting from the importance of housing, adequate income, and meaningful participation for the mental health of us all.

It is critical that the Commission takes a broader view. The role governments play in mental wellbeing is much more than simply providing a set of specific services; they profoundly influence the quality of our physical, working and social environment, which in turn have a major impact on our wellbeing. Fundamentally we need governments to provide physical and policy settings that support mental health and resilience, not undermine them. The key here is understanding the role of stress, particularly persistent stress. Evidence shows that persistent stress exposure generates long-term changes in the brain that predispose many of us to developing mental illness and disorders⁶. When core needs are secure or sufficient, such as housing or enough money to live on, people suffer chronic stress, and these are key factors that government can positively influence for us all.

The value of a secure and liveable income is measured in our wellbeing

There is an overwhelming consensus that government income payments in Australian are set far too low⁷.

As a consequence, people living on income support are trapped in a cycle of growing hardship, poverty, stress, ill health, and a daily struggle for survival that makes finding work even harder.

The current low levels of government income support are therefore a source of significant and persistent stress for the people in our community who are relying on them to survive. Exposure to such stress is known to contribute to the development of mental illness, particularly depression and anxiety⁸. Anglicare Australia over the years has documented the struggle faced by people on low income to put food on the table and look after their children⁹, to afford secure and appropriate housing¹⁰, and to be able to successfully look for work. It is not enough for the Commission to focus on the needs of people with a mental illness trying to navigate life on income support. It is critical that the Commission explicitly recognises that keeping government income payments so low that they are damaging people's health and wellbeing.

The Australian government must also recast the way benefits are calculated, removing the penalties and disincentives presently in place, and allow people to take advantage of incremental and part-time work. There is also strong support for the establishment of an independent commission to consider the cost of living for people receiving income support, and to set these payments and ongoing indexation levels accordingly. This would be in line with community

expectations, as recent research shows that the vast majority of Australians want Australia to be a country which supports those in need, and don't think that anyone deserves to live in poverty.¹¹

The focus of government income support should also not just be the speed with which people can be removed from it. As our member Anglicare WA stated in response to the focus in the issues paper on economic participation

“Greater economic participation can be a positive by-product of increasing mental wellbeing, but should not be the driver of community services and/or mental health programs. While securing and maintaining paid employment may be part of a person’s recovery, it should not be the measure of their worth and whether they, or the program supporting them, are deemed to be successful. In our experience supporting thousands of Western Australians every year, some people will require long term financial and social support to achieve a basic standard of living. The provision of such support should be based on respecting the rights and dignities of all people, rather than measured by the speed with which they can be removed from income support or the extent to which they contribute to national economic growth.”

We hope to see the Commission reflect on these matters in their draft report.

Supporting participation in society, and examining how we work

The issues paper rightly notes that participation in society via work is a critical to our sense of purpose, and hence, wellbeing. It is however critical to understand that employment is not the only way people meaningfully participate in or contribute to society. Non-employment based participation may lead to paid work, or it may be the meaningful and valuable end in of itself. As the Commission states, we should be focused on “how people can be enabled to reach their potential in life, have purpose and meaning, and contribute to the lives of others.” Our member Anglicare WA commented on the issues paper –

“Greater economic participation can be a positive by-product of increasing mental wellbeing, but should not be the driver of community services and/or mental health programs. While securing and maintaining paid employment may be part of a person’s recovery, it should not be the measure of their worth and whether they, or the program supporting them, are deemed to be successful.”

We request that these considerations are taken up by the Commission.

However it is also important that we do pay attention to the changes to working conditions for Australians, and the implications for our mental health. Employment in Australia is increasingly casualised and insecure, and it is clear industrial relations and employment law has not kept up to ensure that people have sufficient pay and conditions¹². Australians also consistently work more hours than they are paid for, further corroding other forms of community participation and connection such as time for family, volunteering, hobbies, and rest¹³. There is considerable evidence suggesting that people working fewer hours and fewer days per week - typically cited as a four day week – are (when paid adequately) more productive, less stressed and have higher

work-life balance and satisfaction¹⁴; Such evidence has largely been ignored in Australia, but deserves thorough investigation including through the lens of fostering and maintaining community mental wellbeing.

Due to the negative impacts of being unemployed being well-understood, there has been an assumption that 'any work is good work'. However, importantly in the context of Australia's increasingly insecure employment landscape, the evidence suggests otherwise. In fact, being in poor quality work can be worse for our mental health than being unemployed¹⁵. People instinctively know this through lived experience, explaining in part why the term "bullshit jobs" has entered quickly into the popular lexicon. It encapsulates the frustration and harm that comes with having to choose between the stress of unemployment, and the dissatisfaction and stress that comes with unsuitable or unrewarding work¹⁶.

It is critical that this understanding is built into how governments approach support for the unemployed, and jobs creation, and for mental health services.

The importance of a home

We ask the Commission to reflect on its recent work on affordable housing, and consider the impact of housing stress in terms of mental health. Housing security is fundamental to people's wellbeing, as Anglicare Sydney have demonstrated through their research and support to clients on low income^{xvii}.

We emphasise again the importance of social housing to ensure that people on low incomes have a secure home, in locations that facilitate them to forge social connections and community. As our Rental Affordability Snapshot shows, the private rental market has completely failed to provide affordable and appropriate secure housing for hundreds of thousands of Australians^{xviii}. This is compounded by the continuation of private tenancy laws that allow no-cause evictions and restrict the ability of people to make a home in their rental property, causing considerable stress, and are particularly damaging to vulnerable populations^{xix}. Investment in social housing and tenancy law reform to ensure that every Australian has a secure and appropriate home would remove a cause of severe stress for many thousands of people. Specific comments on providing housing for people with mental illness are covered in Chapter 4.

The impact of our environment on our wellbeing

Anglicare Australia urges the Commission to consider the evidence on the relationship between our environment - built and natural- and our health and wellbeing. This is particularly relevant to the Commission's focus on how we can reduce the number of Australians diagnosed with mild or moderate mental illness, and design effective paths to recovery for those with moderate and severe mental illness.

There is considerable evidence that our environment impacts upon our mental health. While much of the focus to date has been on understanding the impact of the built environment, in

recent years there has been an increase in research exploring links between human health and wellbeing and the natural environment. Some key findings have been:

- Regular time spent in natural environments improves reported mental health²⁰, is particularly important for children to assist in the promotion and maintenance of wellbeing, lowers stress, and shows promise in terms of measured efficacy for helping people with conditions such as anxiety.²¹
- Gardening, and specifically getting your hands into soil gives exposure to soil bacterium that stimulate brain responses similar to anti-depressants.²²

Higher rates of mental illness for people living in urban environments are thought to have complex causes, including suggesting that a loss of connection with nature is a contributing factor. Given the vast majority of Australia's population lives in urban environments, we should pay attention to the role of the built environment in improving or reducing our mental health.

Urban environments typically result in a loss of protective factors that help mental wellbeing, including social networks, access and ability to exercise regularly, and are often environments of overwhelming stimuli resulting in increased stress responses. Well-documented ways in which urban environments negatively impact mental health are:

- Long commutes by car - are known to induce significant stress levels, which in turn has been linked to an increased likelihood of developing mental ill health. Car dependent-commuting also increases sedentary habits, and this along with other aspects of poor urban design reduce people's exercise rates, which in turn is known to ease the symptoms of and help with the management of anxiety and depression.²³
- Increased social isolation - many people move to cities for work purposes, losing social networks, and the anonymity of a large dense population can be a major barrier to building connection. The design of urban environments to maximise social interaction is thus very important, with well-designed public space critical to helping people foster local, trusting and reciprocal communities within cities, which reduce isolation.

The social isolation faced by many Australians living in rural and remote areas is recognised in our mental health strategies – for example, isolation in rural areas, and lack of access to services is a known significant factor in suicide risk. But given Australia's population distribution is highly urban, it is critical to recognise that densely populated places are no guarantee of shared living arrangements, or social connection. One in four Australians lives alone, representing a significant increase over the last few decades²⁴. These figures point to greater social and family fragmentation, and correlate with rising levels of loneliness, linked to several negative psychological impacts including mental illness²⁵, and social isolation. Notably, loneliness and social isolation are not the same, but both are intertwined with greater levels of mental ill-health; and while it has been thought that mental ill-health typically causes loneliness and social isolation, in fact the evidence points to the reverse²⁶. Anglicare Sydney's report, *Going it Alone*²⁷, provides valuable insight into lone person households on low incomes experiencing social isolation. It showed that people living alone are more likely to be poor and socially isolated, and experience poorer levels of mental health and wellbeing overall.

These findings point to the importance of well-designed cities with efficient core infrastructure such as public transport to reduce car dependency and commuting times. Australia has very poorly designed public transport systems, and notoriously bad car commuting times in our major cities. Outside of our cities, public transport rapidly fades to being non-existent. For Australians on low incomes, the lack of affordable and effective public transport and the cost of running a car creates significant barriers to accessing essential services that support good mental health such as a GP, and increases social isolation. The stress on individuals and flow-on costs in terms of health and wellbeing from car commuting or the inability to travel easily and affordably add to the case to significantly increase government investment in public transport, as part of a recognised response to improving and supporting community mental wellbeing

Fostering social connection

The value of a loving and stable family will be examined in part through the trauma that results from its lack in subsequent chapters, focused on the importance of trauma-informed care. However social connection and networks go beyond the family, and are also important pillars of our wellbeing. Here, the design of our lived environment and policy settings can have a direct impact on social connection, and there is a role for government at a population level.

Access to well-designed public spaces that foster social interaction, the ability to be active as part of daily routines, and feel safe and secure, have been found to be major positive interventions in urban environments that support better mental health and combat social fragmentation and isolation.²⁸ For example, greenspace, particularly as part of active alternatives to car commuting such as walking and cycling, has proven effects to increase mental wellbeing.²⁹ As commented above, regular exercise can help combat mild depression and anxiety. Further, well-designed green spaces are key to encouraging social interaction, reduce chronic noise impacts, and provide restorative local environments.³⁰

Of equal importance are built shared public spaces and resources for programs that foster social connection, both to build connectedness in neighbourhoods and through interest groups, and to give access to basic levels of assistance that address small barriers to greater social participation, that can accumulate to foster social isolation if not addressed. Here there is a strong link with community-based mental health services, which we explore in Chapter 3 of this submission. Public spaces such as community halls, local libraries and event venues are critical infrastructure for supporting activities that help inoculate people from mental ill-health. These issues from an Australian perspective are articulated well in the Grattan Institute's report on social cities³¹.

Recommendations

Anglicare Australia recommends that the Commission:

- Reflects on population level government policy settings that impact the social determinants of health in its draft report;
- Acknowledges the role of these settings in creating risks such as chronic stress, which significantly increases peoples' vulnerability to developing widespread mental illnesses such as anxiety and depression; and

- Make recommendations that capture well-documented changes to government policy settings such as increases to government income payments, and the provision of social housing, which would significantly reduce this negative impact to many people's mental health.

Chapter 3 - Community-based services

Members of the Anglicare Australia Network support many thousands of people through a range of community services including financial counselling and emergency relief, children and family services, housing and homelessness assistance, drug, alcohol and gambling addiction support programs, social connection programs, youth services, disability and aged care services, as well as community-based mental health services including suicide after-care services.

Our Network's experience is that every community service is at least in part, a mental health service, as mental health is impacted upon and will impact all aspects of a person's life. This means any support service can be a door for people needing help with mental illness. What is then critical is that mental health services are readily available as part of an integrated and holistic response. Community-based mental health services conceptualised in this way have a number of significant benefits. They are:

- Person-centred, which allows for treatment and recovery pathways to be co-produced with the individual and any family. This means they can be tailored for cultural appropriateness for example, and other specific needs a person might require to be built into their support for effectiveness.
- Place-based, keeping people connected to their communities and existing support networks; and tailored in recognition of the strengths offered by that community in terms of services and opportunities.
- Accessible without a formal clinical diagnosis, which can be a significant barrier for some people attending services. This allows people with early symptoms of concerns to seek treatment as soon as possible; and is particularly critical for young people, given we know that 75% of mental illness will develop before a person turns 25.
- Holistic, because they enable the identification of and connection to other services a person may need wrapped around them to achieve full recovery and self-management;
- Effective for building mental health and resilience, as well as providing early intervention and acute intervention treatment that help many people avoid, or a forge a recovery path out of, protracted crisis.
- Recovery and management-focused, affordable, flexible and scalable.

As summed up by Anglicare WA, our Network members further configure their community-based mental health services based on the understanding that:

- *“a recovery based approach to mental health practice treats people, not problems;*
- *mental health recovery is impacted by social determinants including (but not limited to) homelessness, domestic violence and financial insecurity;*
- *we must challenge beliefs and practices that are punitive and further stigmatise those with mental health problems and mental illness; and*
- *Our services aim to provide commitment to excellence in interagency, multidisciplinary and evidence based practices in mental health practice.”*

Anglicare Network member, the Brotherhood of St Laurence, in their separate submission, has provided a strong, evidence-based set of principles that should form the framework for designing

our mental health services. They, along with submissions from Anglicare Sydney, Anglicare NT and the Samaritans, provide clear guidance that demonstrates how community-based mental health services situate within that framework.

The following are a number of case studies from community-based mental health services from across the Anglicare Australia Network. They showcase the power and efficacy of community-based mental health services from early intervention to crisis de-escalation and recovery. They demonstrate how place-based service design and delivery creates services tailored to local population needs, including for particularly vulnerable groups; and how they integrate with other services to create a holistic service approach.

Before moving to the case studies, we also want to emphasise the importance of community-based mental health support for family, friends and others who provide informal care to people with mental illness. Anglicare Sydney and The Samaritans cover these issues extensively in their separate submissions, and we provide commentary also from the perspective of system interfaces with the NDIS and aged care. Unfortunately the other small case study we mention below is for a service run by Anglicare WA that is about to cease, as its need beyond the introduction of the NDIS has not been recognised.

Case Studies Series 1 – Early intervention

With 75% of all severe mental illnesses beginning before the age of 25, mental health services that are accessible and appropriate for young people are critical. Several case studies we provide in this chapter document the success of headspace. Another observation is that mental health services need to be embedded in other services for young people to assist with early detection and intervention – The Yes! Housing case study detailed in Case Studies 3 illustrates this.

The case study below from Anglicare SA also demonstrates that it's not just young people who need access to early intervention and integrated supports.

From Anglicare NT – headspace Darwin Prism Group

headspace Darwin has been running Prism, a group for young people aged 12-25 years for over three years. The group is designed to be a safe space to allow same sex attracted and gender diverse young people to socialise and connect with other young people in the LGBTQIA+ community. As a group with a higher risk of social isolation and of developing mental illness, safe spaces for young people who identify as non-heterosexual are critically important; and greatly assist with early detection and service referral for any mental illness.

Anglicare NT use Prism to provide that space, and also to provide education on local services and any topics of interest. Attendance to the group has grown significantly over time and regular feedback from young people highlight the value and importance of such groups in the community.

From Anglicare SA – culturally sensitive care to live beyond suicide

Amal is a 40 year old woman with a 7 year old child. Amal moved to Australia from Iran, and speaks very limited English. Amal's husband suicided, and her friend and neighbour contacted our program, Living Beyond Suicide, to see if Amal could be offered support.

Amal does not work, and had been receiving a carer's benefit as she was the primary carer of her husband. Her husband had always managed the family finances, and all bank accounts in his name, and Amal had no access to the money, she also had a limited knowledge of how to manage the financial matters following her husband's suicide. Amal was unable to pay for her husband's funeral, so with the assistance of Living beyond Suicide worker and an interpreter Amal obtained a funeral payment through Centrelink, and also moved from being on a carers benefit to a more appropriate bereavement pension, and then to a single parent payment.

Amal was connected into financial counselling as she had a number of bills she was unable to pay. Amal was also supported with a number of practical matters including assistance in obtaining school uniforms for her son, and some emergency assistance with food. The Financial Counselling also recommended talking to the Bank and seeing if there were ways they could assist her to manage her Mortgage repayments. Living Beyond Suicide the supported her with the meeting at the Bank, and they worked with her on a management plan, so she could successfully make her repayments.

Amal has been connected to an Arabic speaking counsellor to provide support her with her grief. Amal's son was assisted in developing a "memory box" where he could store photos and other keepsakes from his father.

Without the support Amal has received from AnglicareSA, the combination of grief and financial stress means she is vulnerable and at risk of developing a mental illness herself. The kind of wrap-around intervention service she has received that addresses her multiple needs is critical for minimising that risk.

Case study series 2 –The power of holistic case-management to deal with crisis and complexity

Often there is a misconception that community-based health services can't deal with "serious" issues and do not involve integrated clinical care specialists or clinical governance frameworks.

As Anglicare Central Queensland comments – "There are numerous case studies that reflect the intervention of skilled and compassion workers being able to prevent escalation and treatment at acute centres. Of the 241 people we worked with in this financial year, 65% have through case management, linking to appropriate therapeutic services, and participation in peer groups, reported improvement in their physical, social, emotional and psychological wellbeing...Of the 60 people who have participated in Dialectical Behavioural Therapy skills groups 90% have reported significant improvement in their behaviour, their sense of themselves, their family relationships, their understanding of their illness, their motivation and employment seeking behaviour. 20 of

these people have either engaged with a disability employment agency, obtained voluntary employment, 4 have part time paid employment and others are working towards vocational certificates.”

These case studies demonstrate the power of community-based mental health services to help people with severe, complex and enduring crises successfully progress towards recovery and self-management.

From Anglicare Central Queensland – two client case studies

A 46 year old homeless Aboriginal Man

- *Diagnosed schizophrenia and complex chronic medical issues including epilepsy*
- *homeless for 2 years and had never had a permanent residence*
- *discrimination at Centrelink as did not disclose he was illiterate and did not complete the paperwork that he did not understand he had payment ceased*
- *due to mobility instability was treated by community as “a drunk” and frequently assaulted*
- *supported by one Aboriginal worker in housing*
- *at risk of suicide*
- *feelings of being alone*

This man was referred to the Anglicare CQ Healthy minds service where the majority of support was provided by a skill worker who has lived experience:

- *through advocacy payments were re-established*
- *had notations on the file to ensure future treatment was respectful and helpful*
- *connected with doctor to review medical conditions and necessary pharmacology interventions commenced*
- *reconnected with mental health services and with appropriate treatment voices reduced in audibility.*
- *Accessed crisis housing within Anglicare CQ*
- *Support ranged from 2 to 5 hours a week for the first 3 months until services and support established.*

6 months following entry to service

- *Medical condition stabilized*
- *Mental health condition stabilized*
- *Tenant of house for the first time in life*
- *Connected with peer groups*
- *“I have a friend”*
- *Improved sense of wellbeing and belonging*
- *Beginning to re-establish positive cultural connections*
- *Working towards NDIS*

A 35 Caucasian year old female

- *Diagnosis of Bi-Polar and Borderline Personality Disorder*
- *Has 3 children and living in public housing*
- *Daily self-harming*
- *Childhood trauma*
- *Adult rape*
- *Bi-weekly hospitalisations with serious suicide attempts*
- *Extreme concerns for house management (children slept on mattresses in a cluttered lounge room due to inaccessibility to their room)*
- *Children missing school*
- *At risk of homelessness*
- *Burning mental health service bridges*

This woman was referred to ACQ to a service providing intensive case management and support for people at risk of homelessness. This service allowed for 10 hours service a week. This woman received:

- *intensive case management (up to 5 hours a week) for the first 3 months, beginning with a worker with a high level of experience, person centred but with very firm boundaries*
- *goals established supported at mental health appointments and other appointments,*
- *established a positive relationship with a bulk billing GP with skills and reputation of working in a strengths framework with mental illness*
- *participant through a creative method of drawing goals (short term and long term)*
- *children also involved in goal setting and goals were placed on the refrigerator*
- *house management commenced with persons support (2 skips of household rubbish were removed in the first instance)*
- *Individual trauma informed counselling commenced*
- *budgeting*
- *walking in park, having coffee,*
- *after 3 months the goal of social inclusion*
- *entries to hospital reduced within 6 weeks to one a fortnight (one of these was a serious episode of cutting where the hospital provided first aid and sent the person home at 2 am)*
- *as small steps began to be achieved support was reduced to 3 hours a week and the participant joined a self-esteem group*

8 months following entry to service

- *hospitalisations for 4 months was nil*
- *relationship with children re established*
- *wellbeing improved became a leader in the support group*
- *discharged from mental health*
- *maintained housing (house management continues to be worked on)*
- *Exited from service with all goals met and an invitation to return if required.*

12 months following entry to service

- *part time employment at 10 months and full time employment at 12 months*
- *children achieving at school*
- *13 year old son who was impacted by the episodes received support.*
- *Participant has increased her wellbeing and is enjoying her life.*

From Anglicare SA – two case studies

****Jonathon – 42 year old male - suicide prevention***

Initial contact was made by his mother, who wanted some support to help her manage his suicide ideation. Jon had made a number of attempts over the past few years. The workers visited Jon's parents, they were concerned that Jon was at risk, and thought there was high risk of Jon suiciding. The parents had a number of other concerns about Jon, and how he manages stressors in his life, they did not think Jon would work with the service.

Staff contacted Jon and he agreed to workers visiting. Jon lived alone in a small block of units. He had recently been diagnosed with Asperger's, and was pleased that the worker had previously worked with other people with Asperger's, he thought this would help them understand him. Jon said he didn't really mix with other people in the unit block, and had a strained relationship with his parents.

During the first visit Jon said he thinks about suicide most days, and discussed past attempts. He has permanent physical injuries from one attempt, which impacts on his mobility. During the time working with Jon he has requested support around a number of issues. Which include housing and income? Worker has supported Jon through Centrelink appointments and obtaining a Disability Support Pension, Housing SA and Community Housing applications.

One of the key issues for Jon has been the sense of isolation, Jon didn't work, and lived alone – the worker identified a key interest for Jon was metal & woodwork. The Worker connected Jon into a Project Centre, which is run by local volunteers, where Jon can go and spend 3 days a week in a metal work shop. Jon has been a regular attendee, working with the staff, and they have now asked him to a volunteer role there, supporting other people. Connection into this service has been a positive step for Jon, and has reduced his suicide risk.

Jon let his worker know that when he is at working at the Project Centre he doesn't think about suicide. Involvement ceased with Jon's parents after about five visits – they felt that the support J was getting had helped him obtain his DSP, and get him involved in activities that connected him in with some positive supports

Jane and Mary – complex needs and the success of wrap-around support

Jane lives in the family home with her 64 year old mother Mary and father Ron. Mary cares for Jane who has been diagnosed with paranoid schizophrenia, depression and severe anxiety, and for Ron who has a significant physical disability. Mary contacted AnglicareSA in significant personal crisis in 2010, as a final and desperate plea for help. Mary's extended family had turned their backs on her many years ago as they didn't understand her situation and as she had been housebound for over 18 years, Mary had limited involvement in the community other than going to the shopping centre for groceries at night whilst her husband and daughter were sleeping. Mary discussed her feelings of worthlessness and an overwhelming sense of tiredness. Mary contemplated whether her family appreciated her support as she fielded verbal and emotional abuse daily and wondered how long she was able to endure this day in day out. Mary discussed her ongoing suicidal thoughts as she believed the system would take over the care of her family, if she was no longer able.

Jane is 32 years old. She had not left the home since she returned from high school one day in 1999, after being bullied by classmates and constant feelings people were following her. Jane experienced hearing voices which became louder and more intense once she opened the front door and had refused to go near the door for many years. Jane spent her time watching Netflix and drawing comics. Jane played the Xbox and talked to people online daily. Jane was significantly overweight and found it difficult to get along with her parents as she felt they didn't understand her and asked too many questions.

AnglicareSA through DSS funding of the Mental Health Respite program, was able to implement both immediate and ongoing holistic supports that met both Mary and Jane's needs. A staff member provided immediate counselling assistance over the phone to Mary de-escalating her heightened state of distress and reassuring her that assistance was available. The staff member organised a worker to attend the home the following day to discuss the support needs of Mary and Jane, and to plan initial goals which would pave the way for a brighter future for the family. Respite support began that week with a worker attending the home to build rapport with Jane whilst Mary was able to spend time cleaning or supporting Ron. Over time, Jane began to increasingly trust the worker and agreed to slowly tackle her anxiety relating to leaving the home. At first the worker talked to Jane through a crack in the door, and then as Jane became familiar with this, the worker sat in the patio and talked to Jane whilst she held the door open. 4 months later, Jane held the worker's arm and walked behind her to the letterbox collecting the mail for the first time since high school. Jane and her worker had their first coffee at the local shopping centre 6 and a half months after support began. Jane then began attending the AnglicareSA Mental Health Respite day community engagement groups once a week which gave her mother a day to herself. Almost a year after joining the group, Jane announced that she was enrolling in TAFE and wanted to complete a certificate. Jane is currently working 4 days a week now, has her driver's license and takes her mother to the coffee shop she first went with the worker regularly. Jane lives in her own unit now and comes in to visit AnglicareSA every now and then to give an update on where she is at.

Mary was linked in to counselling immediately and encouraged to contact the program whenever she felt the need for extra support or just an ear to listen. Initially two support workers attended

the home to provide support both to Jane and Mary although, as Jane's dependence on her mother decreased Mary was able to engage in the Carer programs also. Mary attended the I am..Caring 6 week wellbeing program, the self-defence classes which helped to boost her confidence and several other carer events where she cemented friendships and was able to reduce her social isolation.

Mary and Jane's level of support increased and decreased over several years however, they always knew that they had an ongoing, trusting relationship with the program. They were both able to discuss support needs and choose the intensity of their support. They continue to attend events and educational programs where they have built connections and feel able to discuss their journey with others who are just beginning.

Case study series 3 – meeting the needs for particular vulnerable groups

Community mental health services, by nature of being place-based, are well situated to assess local community demographics and needs, and provide appropriately tailored services. Here are some examples from our network. These three examples from Anglicare WA illustrate how this approach works effectively.

Connect for Life Carer Support Services

This service provide a range of flexible respite and support options for carers and families of people with a severe diagnosable mental illness, Autism Spectrum Disorder and intellectual disabilities. The aim of these services is to provide support to carers and families to maintain their caring role whilst making the transition to NDIS and is aimed at assisting carers to sustain their relationships and enhance their own well-being. This program will cease on 30 June 2019.

headspace Pilbara

“headspace Pilbara provides support for young people in relation to their general health, sexual health, mental health, education/vocation, and alcohol and substance use. It is a two-year trial of a unique model, which offers support in communities across the region, unlike typical headspace centres where young people attend a physical headspace centre. headspace Pilbara staff are embedded in schools, youth services, Aboriginal Medical Services, community centres, as well as other locations that allow them to reach young people not typically engaged with school or youth services.

What's working:

- *Adapting quickly based on an ongoing evaluation of the trial. By having the researchers as part of the trial from the beginning, and conducting multiple 'waves' of interviews throughout the program life, we are able to change promptly, based on the findings.*
- *Since there hasn't been an existing youth mental health service in the Pilbara, so there is a great hunger coming from communities to learn how they can assist*

their young people. This gives the service the opportunity to train and provide services without any pre-conceived practices, based on previous services.

- *The mobility of the model, without a centre, allows flexibility for staff as to where they can work from. The very nature of the model means 'siloining' is not an option. It causes creativity, which then propels others to creativity.*
- *Young people are realising that no one set building is the 'right' place to receive assistance or to talk to someone about their concerns. They can talk about it anywhere. Mental health cuts through all facets of life, and we are there when they need us.*
- *We are looked upon as the experts in youth mental health in the region, and we may well be, but this also comes with great responsibility knowing that what we say or do may become the 'norm' for years to come.*
- *Being innovative doesn't just mean the service model; it applies to all methods in how we deliver it. Technology is a big player for us and we are able to trial different ways of working that will decrease administrative functions and increase time spent with young people.*

Challenges:

- *With such a fluid model being placed in a region with quite complex issues, and previously rigid solutions, other organisations, services and local governments struggle to be as fluid. This is not one person's fault; it is systemic and most ground staff have their hands tied.*
- *Due to the requirements of being associated with headspace, including the clinical governance practices and staff qualifications, some see us as being solely responsible for youth mental health in the region. We need to upskill our stakeholders, and walk the journey with them, to share the responsibility.*
- *Knowing that what we are delivering is merely a trial, there is always the thought of 'what if we are creating such a great response to a massive need, and we are taken away? What damage will that do to the region?'*
- *Impact on young people and their mental health is the measure across our project, but how can impact truly be measured in a 2 year trial? How does long-term change get accurately measured in that timeframe? Our largest demographic of young people currently accessing our service is 12-14 year olds. Overall, 40% of young people accessing our service are Aboriginal and Torres Strait Islander. In 10yrs time, what impact have we made on those cohorts of young people that would show what we are doing is working?*
- *Community services in the region are under-resourced to meet the significant demand on the ground. We have a team of three clinical Youth Wellbeing Workers across an area of 500,000 kms. This would be unthinkable in other areas.*

- *Primary health uptake by young people has historically not been well utilised in the Pilbara. All bar one clinic across the entire region is a Private Practice, with the majority GPs on temporary basis as fly-in-fly-out or locums. This makes it especially challenging to develop seamless pathways with GPs. Community members continually say to us: ‘we do not want to repeat our story to lots of people’.*
- *There is no Adult Community Mental Health Facility in the Pilbara. So once a young person turns 25, their only option is Pilbara Mental Health Service, which is usually for those with a diagnosis or showing signs of needing one.*

Social and Economic Impact of Mental Health on the Community:

- *People are falling through the cracks and are only seeking help when their mental health is at crisis levels. This has flow-on effects within their families, workplaces and the community as a whole. People miss work, services become reactive rather than proactive, and many people move away to the city to receive assistance that they cannot get in the Pilbara.*
- *The Pilbara has a fairly transient population due to short-term contracts and the lack of services and amenities. This can lead to a lack of exposure to diversity that would be found in other population centres, in terms of age, disability, gender and sexual identity, and mental health. This lack of exposure can lead to a lack of understanding about what others are facing in the community (i.e. if it’s not in my backyard, it doesn’t happen).”*

Yes! Housing

YES! Housing has been providing support to young people at risk of homelessness for over 20 years, providing support through a case management approach. Whilst previously focusing on public housing and young people with medium-intensity support needs, since 2016 the program has been making significant changes to adapt to the changing housing climate. These changes have included not only looking beyond public housing as the main option for young people, but has also meant that young people with much higher support needs have been accepted onto the program. Due to this, YES! Housing workers have taken on the role as de-facto mental health workers due to the need for young people to have at least semi-stable mental health prior to being able to look at medium to long-term accommodation options.

Furthermore, due to YES! Housing’s flexible case management approach, YES! Housing has become a sought-after service by those with complex clients requiring a stability of service. The service is entirely outreach based, adaptive to the changing circumstances of the client and is able to meet and support clients in a variety of settings including, but not limited to, transporting and attending appointments, providing advocacy support within stakeholder’s meetings, seeing the client in both accommodation and community settings.

Whilst previously YES! Housing had very little in the way of rigorous referral processes (which often left workers unaware of the young person’s mental health needs prior to the

beginning of support), the program has now implemented a more robust way of assessing needs prior to worker allocation. However, this has not reduced the number of young people with mental health concerns applying for the program; it has simply provided the information up front. Further complicating the issue is that whilst some referrers or young people may claim that the client has no mental health concerns, considering the stress and trauma that homelessness creates, many young people with complex barriers to housing suffer some sort of a mental health issue.

Client example – Jessie

Jessie (21yrs) has been engaging with YES! Housing for roughly 4 years, during which time he moved from being homeless and couch surfing to being offered a Department of Housing property with a long-term lease, where he has now been living for the past 2 years.

Jessie experiences many barriers in his life including an extensive trauma history, complex mental health issues including chronic self-harm, ongoing suicidal ideation and high level drug and alcohol misuse and addiction. In addition, Jessie has been the victim of a sexual assault, the victim of domestic violence in two intimate partner relationships and also struggles with gender identity issues, thus increasing his vulnerability and social isolation. At present, Jessie is in the process of handing back his public housing property as it has become a trigger for his PTSD surrounding the sexual assault (which occurred within the unit). Jessie has not lived at the property since this assault roughly 10 months ago and instead has been couch surfing and staying with friends. However, for as long as Jessie continues to have the financial and personal responsibility of this property he will not be able to find alternative, stable accommodation and will not be able to fully move through the trauma of this assault and be able to integrate it into his life experience.

In theory, Jessie’s support once housed should have focused on the building of his independent living skills with an aim to exit him from YES! Housing within 12 months of securing his stable accommodation. This would have allowed Jessie time to build supports and networks within his local community, to be referred to other support services to assist with other goals, and to allow Jessie a step-down approach in terms of his YES! Housing support. However, for the past 18 months the support for Jessie has revolved around crisis management and stabilisation of his mental health, including a new focus of removing the current accommodation, something that whilst positive in the long-term, is increasing his trauma and destabilisation in the short-term.

In addition, within the past six months Jessie has had a serious, near fatal, suicide attempt and a period of drug-induced psychosis which resulted in hospitalisation. During the weeks immediately after the suicide attempt YES! Housing’s support of Jessie increased to 2-3 contacts every day (via phone) and at least one face-to-face appointment each week. The decision to have such intensive contact with Jessie during this time was because he lacks positive social supports and was still experiencing a high level of suicidal ideation. This contact was part of his safety plan in order to assist him to work through this period of high risk. However, Jessie’s suicide risk level generally remains at a moderate – high

level and so much support and contact is provided around stressful times in order to try to assist Jessie to continue to work through this.

Jessie's support needs over at least the next 12 months are only likely to increase as YES! Housing continues to work on the removal of his current house back to Department of Housing (and the sourcing of alternative, stable and safe housing), as well as Jessie's other goal of re-entering a residential detox and rehabilitation centre for his drug addiction issues. Therefore, it is likely that Jessie's suicide risk levels will continue to remain high and thus require additional support from YES! Housing, especially during periods of instability or crisis, in order to help him to remain safe.

Jesse's story illustrates how YES! Housing, a program designed to support young people to secure stable accommodation, provides extensive support to young people experiencing significant trauma and mental health issues. Young people like Jessie are becoming more and more common, thus requiring workers to become more adept at working with, and managing the consequences of, young people's high level mental health issues. This includes providing responsive services and support in times of crisis, working above and beyond the level expected of a traditionally medium-intensity service, and becoming de-facto mental health workers for those clients who either lack mental health support, or those who are engaged in the traditional once-a-week, formal, in-service support. For Jessie, YES! Housing has provided him an informal, flexible, needs-based mental health support in a format that he can actively and comfortably engage with which has been shown to be incredibly helpful and positive.

Recommendations

We have provided the Commission with this relatively large number of case studies to highlight the capacity, flexibility and efficacy of community-based mental health services. Of note is that due to their focus on case management and holistic service support, many demonstrate multiple principles and benefits of this approach in a single case study – be it the value of place-based services, how to tailor support for particularly vulnerable groups, or the ability of community-based services to intervene effectively in times of crisis and implement recovery-based models of care.

These case studies are complimented by the discussion in chapter 4 of effective community-based mental health support for people who fall outside the NDIS.

We recommend that community-based mental health services be restored and significantly boosted in their funding to meet demand, and that the Commission draws on their evidence base in determining effective settings for mental health services across Australia.

Chapter 4 - System interfaces

Income support

Fundamentally, government incomes payments need to be enough for a dignified life, supporting people with mental illness and their carers in recovery, and to participate in society (whether through paid employment or other contributions). The income support system must be accessible to people at their most vulnerable, rather than creating barriers as is the case with current reforms.

The proportion of people with a disability, including psychosocial disability, on Newstart has been increasing following tightening of eligibility for Disability Support Pension. As of September 2018, 24% of people on Newstart or Youth Allowance had a disability³². Long-term unemployment is also becoming entrenched, with 64% of Newstart or Youth Allowance recipients receiving unemployment payments for more than a year, 44% for over two years and 15% for more than five years.³³ Long-term unemployment is often associated with significant decline in mental and physical wellbeing due to decreased connection, opportunities and sense of self-efficacy. Therefore the proportion of people receiving income support who experience mental health issues is likely to be significant.

Changes to the way the income support system is delivered have made it even harder for people experiencing vulnerability to access support. Research from the Anglicare Australia Network, *Paying the price for welfare reform*,³⁴ provides insight into people's lived experience of accessing and interacting with Centrelink, the changes they would like to see and the impact of recent welfare reforms. These reforms include the push to automation and self-service, changes to eligibility criteria and assessment processes and the new compliance framework.

A number of case studies are provided in the report, including from people with mental illness, showing how difficult and stressful the system is to navigate, and how little support is available for them. It revealed, for example, how the majority of Centrelink staff do not receive adequate training to help them recognise vulnerable clients, and de-escalate situations. As Anglicare workers commented, many situations could be minimised or prevented had the staff had the skills to work with customers in a more productive and respectful way, and understand where the client was coming from. The zero tolerance approach to any perceived aggressive behaviour escalated situations and meant support workers were putting a lot of energy into trying to calm their clients.

"Lots of people we work with they get frustrated waiting and then they don't take anything in. If you go in angry they don't deal with you. A lot of these people are in situations where there are trauma issues and their ability to cope is really low. They can't manage those emotions very well while they are trying to get support".

The research also explores the impact on social services, with staff time and resources diverted from core services to support people to navigate the Centrelink system. This research includes recommendations to improve the system to ensure people are able to access income support at

times of vulnerability and are protected rather than falling through the safety net. Anglicare Australia recommends the report to the Commission.

Recommendations

In addition to raising levels of government income payments, Centrelink regulations and practices need to be reformed to remove the emphasis on punishment of people, and to provide more tailored support to people who are mentally ill or similarly vulnerable to assist them to navigate the system.

Housing and homelessness

The link between mental health, housing and homelessness is a complex one, interwoven with factors such as domestic violence, physical health and disability, addiction, social isolation and trauma. Where housing is addressed in isolation from these other issues, people will often cycle in and out of insecure tenancies or homelessness because their underlying challenges remain a constant and are, in fact, often compounded by their housing insecurity.

This is not only about a roof over people's heads. When people have no place to make their own, with the stability and security to take on the other multiple challenges of their lives, they have little opportunity to 'reach their potential, have purpose and meaning, and contribute to the lives of others' (Issues Paper, p. 1).

We therefore need to provide integrated and timely housing support for people experiencing mental illness, underpinned by partnerships across services and the community. This includes:

- Flexible, integrated, person-centred support services and housing options to meet individual need; and
- Building capacity in the community to enable support, dignity and inclusion through housing.

Anglicare Australia Network members run a number of homeless and housing services across the country that incorporate mental health support. Some case studies are given here, and relevant others can be found in Chapter 3, and in the discussion of the interface with justice.

Flexible, integrated, person-centred support services and housing options

There is nothing new about our call for integrated, person-centred care for people experiencing mental illness. The *Issues Paper* notes, for example, a 2014 National Mental Health Commission report that made recommendations for a system in which 'people with a mental illness and their carers can easily access support at the time it is needed' and which considered 'all aspects of a person's life (that is, the 'whole person')'.

However, service systems often continue to be fragmented, responding to specific aspects of client need, such as housing, in isolation from other challenges impacting on their lives; and a chronic shortage of housing options remains. This is an issue right across the continuum of service: without funding more transitional and crisis housing, funding more services to refer high-

need clients to the same limited number of crisis and transitional beds, and the same number of support workers, changes little.

At this high-need level, effective person-centred care depends on highly skilled, holistic support. For this population it is particularly important that service providers work within a trauma-informed, recovery-oriented, 'housing first' case management framework. Effective sub-acute support models are also based on principles of integrated and timely service delivery.

Below are examples of different support services that have been found beneficial across our Network.

Case study 1 – Anglicare South Queensland's Homeless Services Women and Families (HSWF)

HSWF provides temporary support and accommodation for adult women, and young women (16-25 years, pregnant or parenting) and the young women's children, within a trauma-informed, recovery-oriented, 'housing first' case management framework. Approximately 90% of the women at Anglicare Southern Queensland's Homeless Services Women and Families (HSWF) present with diagnosed or undiagnosed mental health issues.

The experience of trauma in a young person's life, often the result of family dysfunction, system failure and/or the impact of social problems and policies, is central to the reason a young person experiences homelessness in the first place³⁵. And trauma, in its various forms, can be a daily occurrence once young people are on the streets. Thus, for young people experiencing homelessness, trauma is both a cause and consequence of homelessness³⁶.

As can be seen in the case study below for 'Amy', our Network member Anglicare Southern Queensland works with service users using a strength-based approach to achieve:

- increased capacity and independence of our service users;
- safety in supporting service users to explore and address the social determinants that have contributed to their homelessness;
- support for service users to obtain sustainable housing by improving their community inclusion and connectedness;
- recognition of our service users' inherent worth and uniqueness and their right to quality service provision; and
- The delivery of services underpinned with the principles of equality, confidentiality and respect for the individual's right to self-determination.

Case Study - Amy's story

Eighteen-year-old Amy entered Homelessness Services Women and Families (HSWF) from the mental health ward of the Sunshine Coast hospital following a suicide attempt. She had spent approximately a week in hospital. Prior to that she had slept rough, after a violent incident which ended her foster care placement.

Amy had no contact with her family, whom she identified as dangerous. She had significant safety concerns around her family being able to find her, and she had no friends and no support other than a cat, which she identified as her most significant support. We supported Amy to

engage with 'Guardians of Animals in Crisis', who found a foster placement for her cat until she had found appropriate housing.

Amy identified having borderline personality disorder, PTSD, depression, anxiety, and dissociative identity disorder, significant self-harm and daily suicidal ideation. The new environment and communal living at HSWF initially triggered Amy's 'other personalities' who would appear as protective strategies. We created a safety plan to support her to manage the space appropriately and be able to engage with the other women. Initially Amy received intensive case management support 3-4 times per week. She also had access to support workers over night and she frequently reached out and engaged in this support. She developed positive relationships with staff and engaged in all onsite activities which were offered – art, music, pampering, cooking etc.

We also linked Amy with the Homeless Health Outreach Team (HHOT) and the Brisbane Rape and Incest Survivors Support Centre (BRISSC) for support with her mental health and to develop further strategies. She met with a psychiatrist and mental health registrar, and received some mental health case management through HHOT. Amy was also linked with 'Talk Suicide' to further explore her suicidality.

As Amy's mental health stabilised, she shared concerns around how she would manage living on her own, as she had never lived alone before. We supported her with daily living skills and continued to develop self-care and coping strategies to manage her triggers. Amy began to settle in the HSWF environment and make some friends. She benefitted from sharing the cooking and meals, engaged in communal chores and took on extra responsibilities where possible.

As we explored housing options with Amy, she identified a wish to live in the community, with supports. She transitioned to an Anglicare community property where she continued to engage in case management. This was initially a turbulent time for her as she experienced triggers around isolation, leading to thoughts of self-harm and alcohol use as coping mechanisms. We completed a new safety plan with her, and again worked together on strategies for managing independently in the community.

Over time, Amy began to settle. Her living skills significantly increased and she thrived from the independence. She identified that she would like to return to school and complete year 12, and we supported her to enrol in a local flexi-school. This supported her engagement in the community and reintegration with her peers. She made friends and developed a social circle which was of further support to her.

Amy identified however that she was still 'getting back on her feet' and that she would benefit from longer term supports. As we explored options with her, Amy identified interest in the Anglicare InSync programme which provides transitional housing for young people under 25. We completed a referral and worked collaboratively with InSync to create a collaborative plan to make this a smooth transition for Amy. She was happy with her move, engaging positively with her new case manager and identifying the move as a positive outcome for her.

After 12 months, Amy transitioned out of Anglicare services and secured a community housing property, where she would have received time limited transitional support. Amy had other support networks that continued to work with her, such as psychologist, youth group and was still linked into the outreach mental health.

Case Study 2 – Anglicare WA’s Foyer Oxford Youth Accommodation Services

Similarly, through Foyer Oxford youth accommodation services, Anglicare Western Australia has identified a gap in the provision of mental health support for young people, particularly those who are either at risk of homelessness or in assisted accommodation. Knowing that homelessness can quickly become a downward spiral, with many homeless people experiencing mental health problems, Anglicare WA is keen to break the cycle of disadvantage and help young people out of this trap.

Over 60% of young people who live at Foyer Oxford have a diagnosed mental health condition, significantly higher than the national average. These are predominantly depressive anxiety disorders, which for some young people can be debilitating, requiring a Tier 4 intervention, the highest level of clinical support available.

General support services at Foyer Oxford are delivered through case management; a one-to-one relationship that supports young people to meet their goals. Each case manager supports 16 residents. Whilst this level of support works for most young people, a complex mental health episode can require more support.

Mental health clinicians, such as nurses, GPs, and clinical psychologists can refer young people into specialist mental health support services where appropriate. Foyer Oxford case managers cannot access these high support opportunities, and young people have to join the long waitlist where periods of more than six months are not uncommon, during which time young people can experience further decline and regression.

Anglicare WA has recently secured philanthropic funding to employ a Mental Health Nurse at Foyer Oxford, to begin later this year. Part of the International Foyer movement, and the largest Foyer project in the world, it is founded on the idea that ending youth homelessness can be achieved through education, training and sustainable employment. The provision of mental health support within this housing service will allow Anglicare WA to assist young people currently struggling with mental health issues and refer them to the formal support they need. By creating an opportunity for a Mental Health Nurse to join the Foyer Oxford team, Anglicare WA will be able to successfully deliver a step-up / step-down model of mental health support through a multi-disciplinary case management approach. Through triage and support, this could enable young people with a complex mental health condition to stabilise and maintain their tenancy with Foyer Oxford, and continue to work towards their goals in education and employment.

Voices of Foyer Oxford residents:

- *“You can have dreams wherever you are. But Foyer makes you feel like you can achieve them.”*

- *“This place has a positive atmosphere, there’s an air of optimism and opportunity. It doesn’t feel like a homeless service – it’s more forward looking than that.”*

However, youth and homelessness services often struggle with accessing acute care for young people who are a risk to themselves or others, with turnaways common. Anglicare Southern Queensland’s youth homeless services work with many young people requiring mental health support. More than half (53%) of the clients of InSync Youth Services in 2017-18 identified as having mental health histories. Further expanding the number of live-in, mental health-supported facilities to support people, particularly young people, with high needs is thus a pressing issue.

Supports to transition into sustainable community living

The importance of community supports in enabling people to successfully transition into community living has been amply demonstrated in previous inquiries and reviews into mental health services. Integrated, person-centred housing-related service delivery models that have been trialled and evaluated include:

- The Queensland Housing and Support Program (HASP) transitions people from extended treatment and Continuing Care Units into living in the community. Results for participants included stability in housing, reduction in Involuntary Treatment Orders, inpatient admissions, and improvements in clinical functioning³⁷.
- The Queensland Project 300 initiative (P300) provided housing, supported accommodation, community access to services and other supports for 300 consumers. Clinical case management was provided by Queensland Health and accommodation by Queensland Housing, with psychosocial support provided by NGO community mental health organisations, with a strong focus on community integration and participation. It operated with the support of, but not within, a medical model. The success of the model was highlighted by reductions in the level of support required by many individuals as they recovered and as informal support networks increased within their own community¹. An evaluation in 2001 found that on average costs for a P300 client were \$15-20,000 less than for people remaining in hospital. Remarkably few disadvantages for the clients were identified, and only 3 of the 218 clients discharged returned to long-term care³⁸.
- The Housing and Support Initiative (HASI), a joint initiative between the NSW departments of Health and Housing and local NGOs, provides coordinated disability support, accommodation and health services to people requiring high-level support to live in the community. A 12-month trial in South Eastern Sydney showed a decrease in inpatient bed days for patients enrolled in HASI from 197 days to 32 days³⁹.

Building capacity in the community to enable support, dignity and inclusion

Inclusion and security – a home, not simply a roof overhead

A Place to Belong is a small organisation working under the Anglicare Southern Queensland umbrella to build inclusion for people who experience mental health challenges, by encouraging and developing the capacity of the community to welcome and include others. This includes building networks of contact and friendship, so that people who have been marginalised can

experience inclusion, acceptance and respect. This approach shifts the focus to building capacity and insight in the community, rather than focusing on the 'deficits' of individuals.

A particular aspect of the work of A Place to Belong relates to the way people connect into their communities and their surrounds. For all of us, but particularly those working toward recovery from mental illness, place is significant. Anna, a resident of Brisbane's West End, describes here how her neighbourhood is important to her sense of belonging:

"A respectful, nurturing environment is important to me, as it is good to be acknowledged within the community. I like it when you go for a walk for a coffee and you bump into people who know you."

Damien le Goullon, an Anglicare staff member at A Place to Belong, explains:

Anna's long term tenure supported the continuity of her community relationships. This meant that Anna had access to well informed situated care when the voices she was hearing began to impact on her and her daughter's wellbeing and her daughter moved out, leaving her living on her own. At this difficult time, Anna took solace in her home and community who helped her to remain connected and get the support she needed, saying "As I live alone with a mental illness, I need good safety nets. Some of my safety nets are the community I live in, my family and friends."⁴⁰

A sense of connection to the stories of a place, however small and individual they may seem, helps people feel like they belong, that they have something to hold on to. Cycling in and out of insecure tenancies, inadequate or unsafe housing, or even social housing provided far from an individual's informal or formal support systems, do little to support people on their journey toward recovery.

Sustaining successful tenancies – building capacity in the community

The issue of insecure tenancy is often a pressing one for people experiencing mental health challenges. The role of multidisciplinary support workers, including drug and alcohol support services, is key in early intervention where challenging behaviours may be putting tenancies at risk.

At the same time, this is a two-sided issue. While social housing providers are likely to have some experience in dealing with complex tenancies, the increased pressure on social housing waitlists is pushing many people into either homelessness, or private sector rentals. Real estate agents and landlords in this sector may have far less training or understanding of the multiple challenges faced by their tenants and fewer resources to handle difficult situations, and thus see eviction as a solution rather than a last resort. Providing targeted, practical training, resources and establishing local advice and support networks for private sector real estate agents has been shown to be a cost effective way to build additional capacity in the community to help sustain complex tenancies. A program of such workshops over several years sponsored by the Northern NSW Health Service has shown positive results, and a similar program will be undertaken by Anglicare Southern Queensland in 2019.

Overseas models

Internationally, the Trieste (Italy) model of mental health service provision has drawn worldwide attention for a proven approach that includes person-centred, easily accessible, community-based intervention and close links with housing, employment and social reintegration, supported by highly skilled specialist mental health services. Significantly, the Trieste model is underpinned by a view that the mental health of the community is everybody's responsibility, and that housing is more than a material requirement for a satisfying and productive life – it is one of the key conduits to social connection, participation and the dignity of the individual.

Recommendations

- Specialist programs for people with mental illness experiencing or at risk of homelessness require a significant increase in funding to meet demand. These services must be based on a trauma-informed, recovery-oriented, 'housing first' and holistic case management framework.
- The significant shortfall in available public and other social housing models must also be addressed through an urgent increase in funding, including for short-term and transition housing.

Skills acquisition, employment and healthy workplaces

Education and Training

The Anglicare Australia Network provides a range of support programs to assist children and young people who have become disengaged with education due to life difficulties, many of whom also experience mental illness. These programs include alternative education programs and support to engage in apprenticeships or other training opportunities.

Young people experiencing mental illness face similar barriers to engaging with education and training as in engaging with employment. This includes stigma and discrimination, limited understanding by the education/training organisation of practices that support positive mental health and lack of knowledge and skills amongst young people regarding how to be resilient and thrive in work and education environments.

There is limited support for people with mental illness who are attempting to engage in the workforce for the first time. Support is particularly crucial for people experiencing mental health issues, given the stigma associated with a mental health diagnosis, and potential episodic nature of their condition. Often support needs to be provided off-site as people may elect not to disclose their diagnosis to their trainer or employer.

The experience of EPIC, an Anglicare Australia Network member who has extensive experience delivering employment support services, is that there needs to be a more coordinated approach to linking young people experiencing mental health issues with specialist employment support. There are a range of national, state and regional mental health initiatives designed to assist young people experiencing psychological distress to improve their wellbeing and connection to community. However, there has been relatively limited success in ensuring those services provide practical outcomes and supports for young people to engage in training and employment. This

could be done through either greater direct employment support or actively linking clients to specialist employment providers who have experience in equipping, placing and supporting young people with mental health issues into employment or training outcomes.

Government support to find and maintain a job

Anglicare Australia believes that everyone's participation is valuable and that the positive benefits of a sense of meaningful contribution should be available to everybody. Such contribution is not limited to paid work, but encompasses volunteer roles, participation in sport and creative pursuits, education and training, community activities, environmental care, and health and wellbeing activities. We advocate for an expanding understanding of contribution beyond simple economic terms, and for increasing creativity in our approach to welfare which enables diverse contributions⁴¹.

As it is, government support to find and maintain work is an essential component of our safety net and crucial to moving towards a society which recognises the dignity and contribution of every person. Unfortunately the current employment services system is not effective in supporting long-term, quality outcomes for people experiencing disadvantage. As acknowledged by the Department of Jobs and Small Business, the jobactive system has largely failed to support people who are most disadvantaged into employment. The Department found that "almost half of the people in jobactive have remained in the service for two years or more. Among the most disadvantaged job seekers (Stream C), the average length of time on the caseload is five years."⁴²

Anglicare Australia has contributed to this Department's consideration of a future employment services system, and the Senate's inquiry into jobactive; and previously released research into the effectiveness of person-centred approaches⁴³. While the recent government announcement of directing more funds to people with barriers to work is pleasing, we remain concerned that an over-reliance on service digitisation, as with Centrelink, may see people with mental illness miss out on vital services. It is hoped that the re-designed job services system will take a person-centred approach to provide better outcomes for people experiencing vulnerability in gaining work. An approach which acknowledges individual differences and situational factors, and recognises peoples' agency, strengths and aspirations, is far more effective in supporting long-term employment outcomes.

Innovative mental health support in Disability Employment Services

Anglicare Australia Network member EPIC Assist (EPIC) is also a leading provider of Disability Employment Services (DES), helping people to find and maintain meaningful employment. Among EPIC's cohort of DES job seekers, 35% have a diagnosed mental health condition as their primary disability. This proportion has been increasing over time. Other DES participants who have an alternative primary disability may also have secondary psychiatric conditions or mental health issues, and there are participants who may have non-diagnosed or non-disclosed mental health conditions.

EPIC been supporting job seekers, including those experiencing a mental health condition, for almost 30 years. EPIC knows that as job seekers look for work, it is not uncommon to experience heightened feelings of vulnerability, low self-esteem and anxiety. Pre-existing conditions may

also be exacerbated. EPIC found that some job seekers required additional support, above what was provided through existing service offerings. To fill this gap, and give job seekers the best chance of employment success, EPIC created a specialised Mental Health Consultancy.

The Mental Health Consultancy is not a requirement as part the DES contract; but it is something EPIC has implemented as a priority, for the wellbeing of the job seekers EPIC supports. EPIC began a pilot project integrating Mental Health Consultancy Services with employment services in 2013.

Results were very encouraging: with 61 percent of participants referred to the Mental Health Consultant achieving a positive employment outcome, and 60 percent of currently employed participants referred to the program maintaining employment (showing a doubling of successful employment outcomes for this group compared to the national rate).⁴⁴

Following the successful pilot, EPIC expanded the model from 2015. Comparing the employment outcome rates of regions with Mental Health Consultants to the rates of similar regions without consultants, EPIC has seen improvements of between 35 to 85 percent.

Currently, EPIC employs a team of six Mental Health Consultants who have expertise in mental health therapeutic approaches and employment services, and are experienced in developing practical skills and strategies for improving mental health. At any one point in time, this team provides direct counselling and therapeutic support to approximately 10 percent of EPIC's entire participant caseload of approximately 3,000 people.

EPIC Mental Health Consultants work directly with the participant and their EPIC DES Employment Consultant to address prevocational barriers associated with challenging psychological symptoms. EPIC Mental Health Consultants provide support to participants to engage in job search activities and build personal skills to overcome issues of depression and anxiety - barriers to finding and maintaining employment. EPIC Mental Health Consultants may also provide support when a participant has been placed in employment if they are experiencing episodic symptoms if their job is potentially at risk.

EPIC Mental Health Consultants have also worked with Personal Helpers and Mentors (PHaMs) providers and have found PHaMs to be a tremendous initiative supporting people with mental health issues to connect with the most suitable community services.

DES participants with an existing mental health diagnosis can be referred to the Mental Health Consultants upon entering the program. EPIC's DES Employment Consultants have been trained to be aware of signs of mental distress in participants they are supporting, and can offer to refer them to the Mental Health Consultancy. If the participant takes up this offer, the participant, Mental Health Consultant and Employment Consultant work together to determine the specific mental health support needed, and how that support will be provided.

Support is always tailored to each individual's needs, and can include anything from self-care techniques, to significant therapeutic interventions, to coordinating referrals and access to housing and specialist services. Some participants prefer group settings, which can help address feelings of isolation associated with mental illness. Others will feel more comfortable and be willing to open up in a one-on-one environment.

The team have worked hard to build strong, trust-based relationships with various organisations to ensure our job seekers' support needs are still met when their needs are outside the scope of EPIC's Mental Health Consultancy. EPIC's Mental Health Consultants have relationships with bulk-billing psychologists, who accept referrals from us and maintain contact to ensure the wellbeing of the job seeker. Mental Health Consultants are also able to assist participants to navigate the complexities of government services and liaise and engage with effective and appropriate allied health and specialist interventions.

EPIC's Mental Health Consultancy is focussed on equipping people with a mental health condition with the tools they need to thrive in a workplace, while also educating employers to understand the individual needs of people with a mental health condition.

Once a job seeker is prepared for a work environment, EPIC's Mental Health Consultant will connect with that person's Employment Consultant to ensure the person's employers have practical tools and tips to understand how to better support them in the workplace. This support may include access to EPIC's mental health workshop.

Offered by EPIC's Registered Training Organisation EPIC Education Assist (RTO ID 41218) this mental health workshop empowers businesses to create a positive environment to confidently support their employees with mental health conditions. The workshop draws on the wealth of knowledge provided by the Mental Health Consultants and staff with lived experience of mental illness. The workshop was developed in partnership with Mental Health @ Work (mh@work), a leading provider of workplace mental health services.

With an increase in the number of people with diagnosed mental health conditions accessing EPIC's services to find a job, it is anticipated that the Mental Health Consultants will not be able to assist all job seekers in-person. To prepare for this possibility, EPIC is currently exploring ways that technology can be better used to provide services to geographically isolated job seekers. This project will ensure job seekers are still able to access the valuable support from EPIC's Mental Health Consultants, regardless of where they live in Australia.

EPIC's development of an integrated Mental Health Consultancy with DES support has shown how successful provision of specialist mental health supports is in supporting wellbeing and employment outcomes. Every participant accessing employment services should have access to specialist mental health support.

Anglicare Australia recommends that the Government explore how to increase such supports, such as through provision of specialist mental health support teams to provide outreach services to employment consultants at every DES service site. The benefit of these teams is to work individually with participants experiencing mental health issues, to support their long term employment outcomes. Mental health consultants embedded in generalist disability employment service teams are also able to provide training to employment consultants on recognising and responding to participants showing initial signs of a mental illness or undiagnosed debilitating mental health symptoms. As shown by EPIC's leading work in this area, such support is beneficial to participants and increases employment outcomes.

The case study below illustrate the challenges faced by people with mental illness engaging in the workforce, and people's incredible determination and capability in doing so. These stories illustrate the impact of combined expert mental health and employment support

Case Study - Donny, EPIC

Donny has come a long way since teaming up with EPIC's Upper Mount Gravatt team over 90 weeks ago. After being out of work for a couple of years, Donny was ready to find support and get back in the workforce. "I have depression, anxiety, sleep apnoea and Graves' disease. I was out of work 2013 and 2014 after the onset of my medical conditions. I was in and out of jobs and found it really hard to find a rhythm," explains Donny. "I have done lots of things in my time, but I am the master of none."

EPIC Mental Health Consultant Snezana has worked closely with Donny for two years, and remains impressed with his attitude and commitment. "From the beginning, Donny was always determined to work with me to address his mental health barriers," says Snezana. "He participated in all our sessions wholeheartedly, completed his homework between sessions and remained committed to making progress and achieving his employment and personal goals."

Donny has now been happily employed with Just Traffic Solutions for six months. His job involves looking after the safety of pedestrians, protecting fellow workers from hazards, setting up sites, signs and road and lane closures, exercising safe work practices and completing paperwork.

"If I didn't have this job, I wouldn't have as much freedom to do the things outside of work that I enjoy doing. It is keeping me in the workforce as a contributing member of society," says Donny. "I'm taking it one day at a time, but I'm feeling positive about life and about the future."

Snezana says Donny's hard work and willingness to tackle issues has also opened doors outside the world of employment. "While Donny is now employed and seeing the positive outcomes of this, he is also engaging in hobbies, socialising and working towards bigger goals over time," says Snezana. "Through the process Donny had good and bad days, and it certainly wasn't painless and easy, but his commitment and perseverance got him through the tougher days."

Donny says his EPIC support network have been an essential component in turning his life around. "Snezana has helped me address my mental health and assisted me to put things into perspective over the last 2 years. I have a long road to journey due to my illnesses, but I know I am not alone," says Donny...."Everyone at EPIC has stuck by me this whole time and have never given up on me. I've needed that kind of support in my life!"

Employment services and the NDIS

The NDIS provides some funding for eligible participants for support to engage in job preparation support programs (under the line item “finding and keeping a job”). However, only limited services are covered and not all NDIS providers offer job search or post-placement support services. There is a lot of uncertainty about access to employment services previously funded by state governments, while negotiations on funding responsibility continue between DSS and the NDIA.

A clear pathway for NDIS participants to access employment services must be established. DES is currently funded by DSS for people with a disability who are able to work a minimum of 8hrs a week. NDIS participants who want to work but are not yet capable of working 8 hours a week should be able to be supported through their NDIS Plan to build their capacity, and then transition to DES for support to gain and maintain employment when they are able and want to work 8hrs per week.

However, despite the fact that underlying funding and sustainability assumptions of the NDIS are based on a significant number of NDIS participants gaining employment, there has been very little inclusion of supports for employment capacity building in NDIS plans. There has been very mixed messages between the NDIA and DSS regarding who is responsible for employment and transition of participants between NDIS and DES. EPIC has shown the success of the pathway of supports where NDIS participants who want to work can develop their skills and capacity within NDIS supports to the point where they can transfer to DES and use that funding to gain employment and receive ongoing support on the job. It will be critical then for NDIS providers to work closely with DES providers to ensure the seamless transition of NDIS participants with an identified interest in securing open employment opportunities across to DES providers with the skills, knowledge and experience to work effectively and efficiently with those future jobseekers.

Mentally healthy workplaces

Part of the Australian community’s response to supporting people experiencing mental health issues needs to be promoting positive mental health at work, and establishing positive and supportive workplace culture. EPIC’s Mental Health Consultant Team support the following principles for creating mentally healthy workplaces, developed by Workplace Health and Safety Queensland:

Leadership commitment: supporting managers and leaders to become literate with respect to mental health issues in their workforce; introducing workplace policies that promote and support psychological safety and workplace practices that encourage flexibility; encouraging respectful and non-discriminatory workplace practices; encouraging honest communication on mental health issues and consultation with workers over how they can be supported if they experience mental issues in the workplace; and building organisational awareness of the importance of addressing mental health issues and promoting psychological safety.

Healthy job-design: Preventing psychological harm that may be present in various workplaces and industries by re-designing job requirements and exposure to specific high stress environments. Employment conditions associated with decreased mental wellbeing include: high job demand conditions; low levels of job control; poor emotional or practical support; reduced role clarity; poor organisational change management (i.e. downsizing or redundancies; introduction of new technology or processes and lack of consultation); poor workplace relationships; lack of reward and recognition; exposure to violent or traumatic incidents; remote or isolated work; and poor environmental conditions. Many of these factors are now associated with casualised jobs in Australia, and show the fundamental importance of secure employment and conditions for good mental health.

Early intervention: Other ways of promoting early intervention include: improving awareness of signs of distress in workers; developing the confidence and skills of managers and co-workers to have meaningful conversations with workers when they appear to be struggling; encouraging early intervention through the Employee Assistance Program or other local mental health support services; for businesses and employers to be willing to make reasonable modifications when they are required; to develop an awareness of how to manage worker disclosure regarding instances of mental health diagnosis or history; developing peer support programs; and having a plan to address exposure to workplace trauma.

Supporting Recovery: Review how an individual workplace environment and practices may have contributed to a deterioration in the mental health of its workers and then redesigning these to prevent psychological injury reoccurring; taking an individual approach to recovery and recognising that each person's response to a mental health issue may be quite different; promoting the importance of continuing to work and re-introduction to work as part of the recovery process; the importance of staying in touch with a worker during their period of absence; developing and using a 'return to work' checklist; involving the worker in the recovery plan and the return to work plan.

It is positive that there are an increasing number of resources being developed and training courses available to support organisations to become more 'mentally healthy'. In this context, it is important that organisations discern good quality training programs that will provide the best outcomes for employees and the organisation. The [Heads up](#) website, operated by the Mentally Healthy Workplace Alliance and Beyond Blue provides an excellent collation of resources. At the government level, for example, Workplace Health and Safety Queensland have developed a 'Mentally Healthy Workplaces Toolkit' and training program aimed at supporting employers to create workplace environments and systems that are supportive of a mentally healthy workforce. This type of initiative is critical in helping Australia to become a leader in de-stigmatising mental illness and creating an environment in which people with mental health issues are seen as equal partners in the world of employment and education opportunities.

Recommendations

- Government employment services require reform and expansion to a) accept and encourage broader forms of participation than just paid work; and b) provide much better case management to people with mental illness, so that they are linked to specialist services and not punished by a rigid system.
- Stronger connections between programs that support young people experiencing mental illness and specialist employment programs need to be developed.
- Funding for specialist employment services for people with a disability should be increased to provide more mental health specialisation and support.
- Consistent inclusion of employment aspirations and funding for specialist support for people with psycho-social disability through the NDIS is required.

Health

Reviewing Anglicare Australia's submission⁴⁵ to the Fifth Mental Health Plan is germane to the questions put forward by the Commission regarding health systems and mental health services.

There have been consistent recommendations for years to create a holistic mental health system co-designed and produced with people who experience mental illness and mental disorders, and starting with non-clinical services in the community, which have fundamentally been ignored. Instead, the focus has remained on sporadic funding boosts for various aspects of clinical intervention, and limited funding for community-based services, in both cases always well below identified need. The result has been:

- the continued atomisation of services;
- a fear of cost as the number of acute and severe cases of mental illness rises rather than an optimistic focus on the multiple benefits of a preventative and well-being community-based approach; and
- a failure to embed mental health expertise and approaches across key systems where people present as most vulnerable, such as the justice system, income and housing support and employment services, further exacerbating demand for services and fostering government reluctance to act on the basis of the problem being "too big".

Into this mix has come the NDIS, where the failure of any level of government to take responsibility for both ensuring the continuation and expansion of existing community-based mental health services; and an effective interface between those services, specialist clinical care and the NDIS, has exacerbated issues further.

The frustration here is that the holistic, co-designed and community-based system with a focus on prevention and recovery that has been recommended for so long, is likely to cost far less than the current approach.

This is the approach taken by Anglicare Australia Network members, and found to be most effective. Chapter 3 contains case studies, and individual submissions to this inquiry from Anglicare Sydney, the Samaritans, Anglicare Victoria, Anglicare NT and the Brotherhood of St Laurence explain in more detail. We urge the Commission to engage deeply with their recommendations.

There are also some critical pieces of infrastructure that are being under-utilised due to lack of funds, and need for some improvements to maximise their value. One good example of this is the Primary Health Networks (PHNs). These provide a much-needed and critical function in assessing population health needs on a geographic and demographic basis and commissioning services accordingly. This is the core of building place-based responses, and most welcome.

However there are limitations with the current system. Many of the PHN areas are very large, and may lack local representation living in rural and regional communities particularly, to have an adequate understanding of commissioning in such communities. Locally based representatives also need to be not limited to collaborating within the health networks, but be able to work across other services and supports including housing, social services and measures provided through workplaces, educational providers and justice system. This is particularly important for commissioning effective community-based mental health services, which are often best embedded in other services and work across disciplines and sectors, including but not limited to clinical health responses, to produce the best results.

PHNs are also more frequently funding community-based mental health services that require a formal diagnosis for eligibility. This removes one of the most important benefits of many community-based services, which deliberately do not require this as it is a recognised barrier for many people wanting to seek help. In particular, it works against the principles of early intervention and recovery-based support. This issue is explored further in this chapter under psychosocial support.

Rural and remote services

Rural and remote areas of Australia struggle across the board to access sufficient mental health services in all forms. Some examples of effective community-based health services in rural and remote settings were provided in Chapter 3, and others can be found in Appendix x, and in the separate submission by Anglicare NT. For the sake of ease we have placed other rural and remote service considerations under the broader health system, given it has the largest interface.

The difficulties of accessing quality mental health services are further exacerbated in rural and remote areas. These difficulties are clearly seen in the case study from Willochra Home (provided in separate submission on aged care), where public services are unable to cover the cost of travel and accommodation to send a staff member, private services are unavailable and cost-prohibitive, and the client is unable to travel to services in other regions.

Overcoming the challenges faced by services in rural areas requires recognition of the barriers faced by both people experiencing mental illness and those who provide formal and informal support. These barriers include social isolation and stigma, lack of cultural safe services and high staff turnover in acute mental health teams and Emergency Departments. It must also not be forgotten that isolation in rural areas, and lack of access to services is a significant factor in suicide risk.

The cost of transport in rural Australia is a significant barrier. For example, one network member providing services in rural Australia, Anglicare Central Queensland, covers an area greater than the size of Denmark. There is no public transport in this area. Anglicare Central Queensland advises that the cost of service delivery in these areas is unsustainable within current mental health services budgets to provide the required amount of face to face services for people in geographical areas located away from the main population centres. More support is needed to be able to provide effective preventative services supporting the identification and escalation of mental illness.

Short term contracting also impacts on staff, clients and the quality of services. As in Anglicare Central Queensland's experience, the building of teams to most effectively deliver recovery oriented and person centred services across 5 sites and 60,000 kilometres takes time, intensive support and consistency. Yearly contracts and delayed notification of tender outcomes are a huge barrier to this. Regardless of how passionate they are about working with people experiencing mental illness, staff need work security. Experience (and data from the NDIS) also shows that the best outcomes for clients are where there is a good relationship with the worker. The stability of long term contracting is needed to support this best match and relationship building between clients and staff.

Additional resourcing to support face to face to services in rural and remote Australia is essential to supporting the best outcomes for people experiencing mental illness, and to support prevention, recovery and participation. Availability of intensive services in a familiar environment for those with severe and persistent complex illness is needed, as well as resourcing for mental health peer workers, generalist counselling and suitable supervision for all workers.

While not suitable in all situations, the use of tele-health services can be an effective way to provide access to some mental health support services for people in rural areas. Anglicare Australia Network member EPIC Assist has had success in a trial of tele-health services for providing mental health assistance to participants accessing their Disability Employment Services, and this case study is given below.

Case study: Successful pilot of tele-health services for rural Australia – EPIC Assist

EPIC currently employs six Mental Health Consultants and a full-time Mental Health Coordinator to deliver mental health services directly to 20 of EPIC's Service Centres in metro and regional Queensland and Tasmania. In 2018, EPIC commenced a Remote Servicing Pilot, with the aim to extend mental health services to the 30 Service Centres not directly serviced by a visiting Mental Health Consultant. These sites are in rural and metro Queensland, regional Northern NSW, and regional and remote Tasmania. Remote provision of mental health interventions is the most researched area of tele-health. Telehealth consulting has been found to:

- be as accurate as in-person consultation for psychiatric diagnosis;
- produce similar outcomes in psychotherapy treatment including cognitive behaviour therapy (the evidence covers conditions such as PTSD, other anxiety disorders, anorexia, and mood disorders);
- be equivalent to face to face for assessing and treating psychosis; and
- Does not trigger symptomatology in patients with schizophrenia.

This pilot involved EPIC Employment Consultants from four EPIC Service Centres in the Cairns region making referrals to a Mental Health Consultant (registered psychologist) on the Sunshine Coast. A review of the four-month trial found that it demonstrated that it was possible to provide quality mental health services to Disability Employment Service (DES) participants using a basic tele-health model.

The review also found that the pilot's success was due to the training delivered by EPIC's Mental Health Consultants to Employment Consultants [to ensure they understand and were well equipped to effectively support the participant through the process.] on the following topics:

- The advantages and limitations of tele-health support;
- Identification and selection of the most appropriate participants to refer to a Mental Health Consultant (MHC);
- Confidentiality, Limitations of Confidentiality, and Duty of Care;
- The referral and assessment process, and EPIC MHC's current Stepped Level of Care Model;
- Working with their MHC to ensure that therapeutic recommendations, referrals to external support services and job search goals were understood and actioned; and
- The importance of ongoing Disability Employment Services support after each participant completed their referral period with the MHC.

As a result, of the success of the pilot, EPIC is now extending this remote servicing initiative to all Service Centres not currently visited on a weekly/fortnightly basis by an EPIC Mental Health Consultant. While EPIC Mental Health Consultants are able to provide high-quality tele-health services to remote sites, much of the work of the Consultants depends on the ability to make additional cross-referrals to specialist support services such as specialist mental health services, drug and alcohol services and accommodation support. The success of this tele-health initiative will be further enhanced as consultants continue to develop their connections with services on the ground, and as additional services are funded in regional areas.

However it is critical that the Commission understands that video- and online services cannot and must not be seen as the panacea for providing them to rural and regional Australia. As one of our rural providers, Anglicare Central Queensland succinctly put it -

“Here are a few therapeutic approaches that are difficult or nearly impossible to conduct online:

- *Animal-Assisted Psychotherapy*
- *Art Therapy*
- *Drama Therapy*
- *Expressive Arts Therapy*
- *Eye Movement Desensitization and Reprocessing Therapy [EMDR]*
- *Music Therapy*
- *Play Therapy”*

In their submission, Anglicare NT pick up this point for remote communities, particularly to assist Aboriginal people to remain on country as part of culturally appropriate care: –

“Being on country is critical for recovery. A person-centred approach to mental health care requires a dramatic re-evaluation of the mental health services provided to regional and remote Australia. The use of telehealth is increasing, however, expanding on this by creating viable and sustainable (appropriately funded) secondary consultation pathways are required. This could include establishing positions to link specialist services in larger metropolitan areas with local health and care coordinators in regional and remote communities. This pathway not only increases accessibility to specialist mental health services, it increases the linkages and support for local community health workers.”

Rural, regional and remotely based Australians need and deserve the same range of effective and appropriate therapies. As the case study below notes, tele-health can be effective, but if there are a lack of on-the ground services to refer a person to, structural weaknesses – i.e. a fundamental lack of service capacity in rural and remote Australia - remain unsolved.

Recommendations

- Systemic reform requires adequate and sustainable funding for mental health services, with community-based services at their core. The PHNs can be a cornerstone for providing place-based population assessments of need and commissioning integrated mental health services that match it. However they must be adequately resourced, geographically appropriate to ensure representation and knowledge of the needs of rural and remote communities, and not limited to medical models of intervention.
- Remote and rural mental health services need a significant boost in funding configured to recognise the low level of active providers, and need to create continuity and sustainability of service.
- Telehealth can assist with some stages of mental health support but is not a replacement for desperately needed face to face mental health services in rural and remote Australia.

Justice and child safety

Our member agency The Samaritans have provided some useful evidence based on their service experience on ways we could improve systems to avoid so many people with mental illness ending up in the justice system.

People experiencing homelessness, or discharged into insecure housing from institutions such as hospitals or correctional centres, for example, often also have experience of trauma that relates to mental illness, social isolation and/or addiction. Associated challenging behaviours may have 'burnt bridges' in accessing some mainstream systems, such as housing supports. Alternatives are needed. In Queensland, state government funding enables organisations such as Anglicare Southern Queensland to provide referral and support services that offer an alternative to detention or prison.

Anglicare South Queensland and other members also emphasise the importance of step up / step down services. Step Up / Step Down (SU/SD)-type services provide short term (up to 28 days) residential support as an alternative to hospitalisation (step up) or ending up in crisis that may involve contact with the justice system; or transition from hospital back into the community (step down). People accessing the service as a 'step up' may simply be referred by a general practitioner or community-based mental health service, or self-refer if they feel in need of additional support as part of their personal recovery plan. Residents usually have 24-hour access to specialist mental health staff as well as being supported through group and 1:1 activities to strengthen relationships with family and friends, and grow their skills for living safely in the community⁴⁶. In this way, non-clinical supports are as integral and important to recovery as clinical care. However, these type of services are not the norm across all states. This is particularly unfortunate as people with untreated sub-acute support needs may be forced into more costly acute support services at a later stage.

Case Study - Sally's story

Sally was 46 years old, single and job-seeking when she referred to Anglicare SQ's Homelessness Services Women & Families (HSWF). She had not had her own place for many years, and had spent many months in hospital over the past few years. In between hospital stays she stayed temporarily with friends or family, or lived in her car when she could not find someone to stay with or she felt she had 'outstayed her welcome'. She had never sought the support of social services, including emergency or temporary accommodation.

It became very apparent that Sally experienced significant mental illness from time to time, which had led to the lengthy hospital stays. She told us that she experienced Major Depressive Disorder, Anxiety and Obsessive Compulsive Disorder. While she presented as low risk, she also had very high needs. Sometimes she could be trapped in her ensuite at HSWF for hours, as she couldn't bring herself to cross the door opening to enter the main part of her room.

Sally stayed with HSWF for eight months, with experiences in and out of hospital during this time. She maintained ongoing engagement with her psychiatrist, and short term

hospital-based therapies during her stays were helpful, but she continued to need the support of HSWF and was always discharged back to our service.

Sally found it difficult to explore alternative housing options as she identified feeling safe and secure in the Anglicare accommodation, and greatly appreciated the support she received. She did not wish to leave, but HSWF offers only short-term, temporary accommodation. We supported her to move to transitional accommodation, and referred her to mental health support services to provide ongoing support.

Sally's move to boarding style accommodation was short-lived, lasting only six weeks before she was re-admitted to hospital. HSWF made a new referral to longer term housing, but this option was then, and continues to be, unavailable for her.

We don't know where Sally is now. With longer term housing, and the support of a Step Up / Step Down-type system to support her mental health needs, Sally's potential to live a purposeful and meaningful life on her own terms would be much enhanced.

Young people and the justice system, and mental health

Many of Anglicare Australia Network members work with youth who come into contact with the care system, justice system and/or who experience homelessness. There are some common denominators for these young people: early neglect, abuse and complex trauma. We particularly draw the Commission's attention to the separate submission from Anglicare Victoria, and the recommendations regarding the implementation of the *Home Stretch* campaign.

Young people who are more likely to have experienced trauma include those in out-of-home care, in the juvenile justice system, those experiencing homelessness, young refugees or asylum seekers, Aboriginal or Torres Strait Islander young people, and young people working in emergency services⁴⁷. It has been found that 81 per cent of young women and 57 per cent of young men in custody had been abused or neglected, and for 49 per cent of the young women and 19 per cent of the young men, that abuse or neglect was "severe"⁴⁸. The real number is likely to be higher, as we know that many young people either deny or under-report these experiences⁴⁹.

Although there are no national data available on the reasons children are placed in out-of-home care, studies indicate that children enter care from increasingly complex family situations. We know that child abuse and/or neglect are the primary reasons given, whilst parental substance abuse is also frequently reported, followed by domestic violence and mental illness⁵⁰.

Homeless young people typically come from disadvantaged and dysfunctional families, and maltreatment is often the impetus for a young person to leave home. Homeless maltreated young people may have run away from home to avoid the maltreatment, been asked to leave home, or been placed in out-of-home care.⁵¹

These situations all involve serious trauma to children and families. Trauma and neglect can lead to a wide range of mental health difficulties, include post-traumatic stress disorder, anxiety,

depression, substance abuse, borderline personality disorder, and eating disorders⁵². Trauma does not always lead to mental ill-health in young people, but any type of trauma has the potential to be very damaging to a young person's mental health, particularly if they do not get the support they need early on.

Trauma adds to the risk of offending behaviour, contributing to the link between child maltreatment, homelessness and offending. Experiences of trauma can lead to poor self-regulation and coping skills which may be exacerbated by any substance abuse, placing the young person at high risk for serious illegal behaviour.⁵³

The link between out-of-home care and offending has long been established. Children in care are 68 times more likely than other children to appear before the Children's Court, with 56.5 per cent of young people appearing before the Court thought to be in care⁵⁴.

As the Productivity Commission emphasised in the issues paper, there are sharply elevated rates of mental illness among young people that child protection authorities have placed in out-of-home care and young people that have left state care. Furthermore, the share of people with a mental illness is much higher in the justice system than in the general population.

It is clear that the response of the child protection and justice system to mental health issues are inadequate, and not reflective of the evidence on prevalence, risk and outcomes of young people interacting with these systems.

Anglicare Australia is calling for a much greater focus on prevention and early intervention programs – particularly programs that work to strengthen family functioning and skills – as this will deliver significant outcomes in terms of better mental health and wellbeing for children and young people. These approaches should recognise that the best way to make a child safe and thriving is to ensure that the family environment is safe and nurturing. To work in the best interests of children, we must ensure the wider support networks are strong and supportive. This means purposeful investment in supporting families to provide a safe and nurturing environment in which children can develop⁵⁵.

Addressing family functioning and skills

It is critical for early intervention support to sit outside the statutory child protection system, which often operates within a risk-adverse, crisis-driven culture. It also creates gaps in service responses and missed prevention opportunities to respond to children not screened into the system. John Lynch's data⁵⁶ (2018) shows that children who are not screened in experience twice the level of vulnerability throughout their life (35%) compared to those without any contact with the child protection system (17%). We need to find ways to better respond to families who don't receive follow up responses and supports within the formal statutory system.

A coherent national response to child and family disadvantage is needed at both population and local levels. It should rest on a strong universal system that leverages services and recognises that some children, families and communities require different and greater support. Measures

that identify and prevent vulnerabilities, and in turn improve early learning and development outcomes must be in the frame. This is the foundation of wellbeing and reducing the risks of harmful circumstances to children. Keeping children safe so that they can experience wellbeing over a lifetime will require mutually reinforcing support early in a child's life, provided over a sustained period.

There is an opportunity to strengthen key services, regardless of which level of government funds them, and connect these with more intensive, targeted and specialist services. This would create a navigable continuum of support. With the goal of identifying emerging vulnerabilities and connecting families with additional supports, the earliest public health responses could take shape through expansion and collaboration of the following systems:

- Strengthening the universal platform of maternal and child health, which is so variable across the nation, would better assist families in the earliest stages of their children's life. Interventions aimed at improving and sustaining the parenting capacity and family environment are particularly important to improving the safety and wellbeing of children⁵⁷. And it is critical that a service response takes place immediately after the birth of a child, as the highest likelihood of for example family violence occurs at this transition stage for a family⁵⁸.
- Early childhood education and care could provide a crucial soft entry point to engage with families. Anglicare Australia supports proposals to ensure that every three year-old Australian can get access to fifteen hours of subsidised early childhood education. Other strategies to increase participation of vulnerable groups in early learning settings are also needed.
- Social security and housing reforms are needed to ensure adequate income support and stable homes so that children are not living in poverty and housing insecurity.
- The NDIS platform could be leveraged to support the development and wellbeing of children of parents with disability, and siblings of children with disability.

There is a systemic need to engage with harder to reach families. Gaps remain in outreach for formal early learning experiences, building cultural safety, strengthening inclusion and parenting skills and eliminating financial barriers. While some programs exist – such as the Brotherhood of Laurence's Refugee Child Outreach and HIPPIY programs – they are few and far between. There is a need to invest in measures that increase participation of vulnerable groups in early learning as an effective and public health strategy (for example, outreach, readiness programs, and inclusive practices).

As the families who can benefit most from support are less likely to engage with formal early learning⁵⁹, home-based options are the most effective for the prevention of harm to children (for example, the family nurse practitioner model). They offer a window into the home environment, which can provide the trigger for families to be linked to other services. Home-based options also offer a cost-effective and nimble approach that does not rely on physical infrastructure.

Existing preventative home-visiting programs exist but are only available to a small number of families in select locations. There is an opportunity to entrench these approaches to ensure they are available nation-wide for families and communities that would most benefit.

We believe that establishing Integrated Family & Community Hubs would provide an opportunity to align resources and efforts – federal, state, local and community – with the purpose of tackling developmental vulnerability in children living in locations of disadvantage.

The hubs could provide a coordinated gateway into a range of support, making it easier for families to connect with the assistance they need. Hubs would also have an intentional approach to identify and engage harder to reach families. They would operate using a place-based approach, with their efforts tailored for local circumstances.

Anglicare Australia believes that any public health approach for enhancing children’s safety and wellbeing should also be concerned about preventing recurrent child removal and expedite family reunification. Research⁶⁰ by Anglicare Tasmania’s Social Action and Research Centre shows several system failures:

- Cross-departmental collaboration is needed to ensure that intensive family support is available during pregnancy. This would help prevent child removal by addressing safety concerns where a baby alert is flagged by child protection services. For example, there needs to be tailored family support and therapeutic treatment for parents struggling with addiction who are at risk of permanently losing their child.
- Cross-departmental collaboration is needed to ensure that pre- and post- child removal family support services are available to all parents involved with child protection services. This would improve the chances of family preservation and expedite family reunification, and their ability to parent in the longer-term, whether or not their children are returned. This should include a continuous case management model of intensive therapeutic support for parents as well as practical support, delivered at arm’s length from child protection services. The programs should be responsive to the differing needs of different demographic groups and enable support to be delivered at varying levels of intensity.
- Relevant federal and state government departments should explore programs that address continued parenting costs after child removal and the costs involved in family reunification.
- Relevant federal and state government departments should ensure that there are options to support families involved with child protection services to maintain stable accommodation, especially where accommodation has been identified as either a risk to child safety or as a barrier to family reunification. These may be tailored to where parents are in the reunification journey and their level of support needs.

Therapeutic trauma informed intervention and care for children and young people

Early intervention and prevention processes are important to ensure that young people receive the support they need and avoid the criminal justice system. An adequate and appropriate response earlier on can support young people to work through their traumatic experiences. We need to increase culturally and gender sensitive support for children and young people with mental ill health living in the most socially disadvantaged communities across Australia.

Interventions should address both the physical and psychosocial needs of young people, such as appropriate safe housing and complex trauma interventions. “Trauma-informed care is an approach that seeks to recognise, understand and respond to the impact that trauma, particularly complex trauma, has had on the lives of young people with the overall goal in establishing safety, both physically and emotionally, for youth and case managers and moving youth towards a place of healing and empowerment”⁶¹. Complex trauma has extensive and lasting impact on normative child and youth development and understanding this impact is essential for any case managers dealing with children and young people at risk.

Special attention should be given to intergenerational trauma – the impact of ongoing, collective trauma for Aboriginal and Torres Strait Islander children linked to the lasting impact of colonisation, which has left and continues to leave a legacy of violence, family separation, loss of culture, language and country. The increasing number of child and youth suicides in Aboriginal and Torres Strait Islander communities is of deep concern and demands an urgent response.

Evidence-based intervention strategies, with a strength-based approach, such as Functional Family Therapy, Multi systemic Therapy and Multidimensional Therapeutic Foster Care, all provide appropriate frameworks for engaging and supporting young people at risk⁶².

There is a need to address the capacity and skills shortage in out-of-home care and justice system of trauma-informed care – as well as frontline services (such as Centrelink, housing and education). The Sanctuary Model, for example, recognises that trauma has an impact not only on the people who have experienced it, but also on the staff who work with them and on organisations as a whole. Sanctuary enables an organisation to create a safe, non-violent environment and relationships that teach people to cope more effectively with stress and trauma⁶³.

It is promising that Victims Services NSW has begun trauma-informed training of staff within detention settings, including a recent trial to provide counselling for juvenile detainees who had been the victim of interpersonal violence⁶⁴. This should be mainstream. Better awareness and capability of all staff in the criminal justice system will be critical to reducing the re-traumatisation of individuals, and increasing engagement in rehabilitative programs. Further, we believe that the poor outcomes for young people leaving residential care provides ample evidence for the need for all residential care services to be resourced and funded to deliver therapeutic models of care. In Victoria, for example, only some residential care services are funded as therapeutic residential care.

Young people, mental illness and justice settings

We strongly support raising the minimum age of criminal responsibility to at least 14 years, reflecting an international evidence base that shows that adolescent brains are still in a state of development, and that trauma and neglect further delay high level reasoning skills. We also support the diversion of young people from the court system wherever possible.

Keeping young people out of detention should be a major priority of a Youth Justice Strategy. Where young people do come in contact with the justice system, Anglicare strongly supports, and has evidence of the efficacy of, a holistic, trauma-informed approach that endeavours to understand the basis for offending, addresses disadvantage and stressors, and provides individualised support for the young person and their family. This includes extending support through post release and transitional programs into the very vulnerable period of reintegration into the community.

Effective youth justice strategies require government and community to expand and strengthen the ways we work together across sectoral and agency silos, recognising the shared responsibility we hold for the welfare of our young people, and the social conditions and relationships which promote both crime and community peace and safety⁶⁵.

Holistic Procurement approach

Current contracts typically provide a solution to a particular symptom, such as mental health, drug and alcohol, food relief, financial counselling, parenting. When funding is siloed, it makes true collaboration across service areas very challenging and the best interest of the child and youth is not. Instead, providers should be encouraged to consider families and young people in their whole context, and address safety and family functioning within it.

A comprehensive intake approach within mainstream services could be used to identify complexity in families that present with higher risk, to connect them to needed services sooner. Again, resource and cultural shifts would be needed to drive this. *The Protecting and Nurturing Children: Building Capacity Building Bridges* initiative is one positive example of this.

Recommendations

- Increase access to early childhood education, and funding for maternal health programs and other early intervention programs that address family function and skills through trauma-informed therapeutic approaches.
- Raise the criminal age of responsibility to at least 14, and fund holistic, trauma-informed therapeutic interventions and case management for young people experiencing mental illness who enter the justice system.
- Increase funding for step up / step down programs including transition housing options, to help people with mental illness avoid contact with the justice system due to a lack of other options such as after discharge from an institution.

Community mental health and psychosocial support services

As outlined in Chapter 3, accessible community mental health supports are an essential component of our safety net supporting the wellbeing and contribution of all members of society. The Anglicare Australia Network sees the enormous benefit of these services to individuals, the community, and the sustainability of our support system. We are concerned that with changes in transition to the NDIS, these supports and benefits are being eroded. As identified by the Commission, there are significant gaps emerging for people experiencing mental illness who are not eligible or choose not to access the NDIS. We also refer you to Anglicare Sydney's separate submission to this inquiry.

Eligibility and access to the NDIS

While funding previously allocated for community mental health services has been pooled into the NDIS, it has been estimated only two-thirds of the 690,000 Australians living with severe mental illness will be ineligible for the NDIS⁶⁶. AnglicareSA's experience to date is that only 12% of Personal Helpers and Mentors (PHaMs) clients have been deemed eligible for NDIS funding, despite PHaMs being classified as completely in-scope for NDIS transition.

An audit by AnglicareSA of PHaMs clients indicated that the clinical 'psychotic' disorders considered in-scope for the NDIS, such as schizophrenia, bipolar and schizo affective disorder account for approximately 30% of PHaMs clients' diagnoses. Severe Depression, PTSD and anxiety (often experienced together), account for nearly 70% of participants' diagnoses. To date this cohort has not consistently been found eligible for NDIS funding, and in the current environment, there are limited alternative services to refer clients to. Similarly, Anglicare Tasmania found that in a recent consultation with Tasmania's Partners in Recovery (PIR) Consortium it was estimated 38% of PIR clients in Tasmania who had a current diagnosis would be unlikely to be eligible for NDIS funding.

There are multiple reasons that people accessing PHaMs, Partners in Recovery (PIR) and Day to Day Living (D2DL) may not meet eligibility criteria for the NDIS. These programs provide broad community-based support for people who recognise they need support to live with severe mental health challenges. These programs do not require a formal diagnosis or record of mental illness, hence many clients do not have ongoing relationships with medical professionals who can support an NDIS application should they wish. People can self-refer rather than needing a clinical referral and the programs do not require a mental illness to be 'permanent'. Such an approach enables a broad spectrum of people living with mental illness to manage their mental health, maintain relationships with family, friends and within their communities and to participate in education and employment.

In contrast, the NDIS requires applicants to undertake both diagnostic and assessment processes which confirm their functional impairments are permanent and severe in order to access psychosocial supports. This additional barrier means that many people who would potentially be eligible for the NDIS will not access these services.

AnglicareSA has found that many clients with mild to moderate mental illness have been unable to or do not wish to establish the clinical relationships necessary to obtain medical

documentation to establish a life-long diagnosis, which is necessary to ensure continuity of supports. Clients have chosen to disengage from support services rather than endure the lengthy process of NDIS rejection and review. While a very understandable decision, this will likely result in increased severity of mental illness symptoms and impacts for these clients, their informal supports and other service systems.

Clients have voiced their perception that some NDIS service providers may simply be wanting their business and money, rather than being motivated by the desire to help people improve their lives and change their situation. This change from a relational foundation to more transactional approach can deeply affect people's willingness to engage with services in challenging situations.

The gradual cessation of these mental health supports is impacting both on those who accessed supports and their wider networks. AnglicareSA has found that people now ineligible for NDIS funding or unable to access community based supports previously available to all community members, are now unable to access supports that assist with tasks such as visiting elderly, sick or isolated family members, resulting in vital relationships breaking down. There are further impacts as people with complex needs are now unable to attend or make appointments with other crucial services including Centrelink, Medicare and the Public Trustee, and difficulty in maintaining payment of bills and other essential everyday living tasks. The emerging gap between the NDIS and previously funded community mental health programs is therefore leaving people experiencing mental illness, as well as their informal care networks, at great risk.

For those who have applied to the NDIS, Anglicare Australia members report that psychological distress and relapse into mental health crisis has been a common trend after discussion around the application process. Symptoms of mental illness have noticeably increased due to the extended, complex application process and rejections stating unmet criteria. For example, an Anglicare SA worker noted increased use of alcohol and other drugs by a client, who said that rejection from the NDIS was the reason for their increased distress.

These barriers and additional stresses faced by people who have been relying on community mental health services in transitioning to the NDIS are illustrated in the case study below.

Case study: Sarah's experience with the NDIS, Anglicare SA

Sarah is 38 years old and has a diagnosis of bipolar affective disorder, major depression and anxiety. Sarah was also recently diagnosed with diabetes, and suffers from a bulging disk, causing excruciating pain and limiting her physical ability to do many tasks around the home.

Sarah self-referred to AnglicareSA's PHaMs program in July 2016, and engages in the following services and supports:

- *Support to build confidence and reduce social anxiety*
- *Support to reduce social isolation*
- *Support with managing diet, health, wellbeing*
- *Support with study and volunteering*
- *Advocacy with other agencies*

- *Mentoring around mental health issues*
- *Increased knowledge and awareness of mental illness*
- *Strategies to deal with the challenging days*

Sarah experiences many negative symptoms of her mental illness – some are a direct result of requiring anti-psychotic/mood stabilising medications. Extensive attempts with various medication combinations to try and stabilise/minimise Sarah’s symptoms have been a great cause of distress for her. She has experienced major hair loss, a severe body rash which has resulted in scarring, learning difficulties (simple tasks), poor concentration and greatly reduced memory. Sarah has worked together with her psychiatrist to achieve optimal levels of medication to keep her stable and free from episodes of mania and major depressive symptoms. Further to this, the impact of her illness on her life is as follows: sleeping excessively, constant fatigue, insomnia, sleep apnoea, weight gain, diabetes, difficulty maintaining her home and garden due to inability to organise these tasks and constant back pain, poor personal hygiene, parenting difficulties (single parent of 3 children), inability to work or study, social isolation and poor relationships. Sarah has extremely low self-esteem and lives with chronic feelings of hopelessness. Sarah describes at times feeling completely overwhelmed by the simplest daily tasks, which in turn triggers more feelings of hopelessness, frustration, shame, guilt and fear. Sarah has hopes of becoming empowered so she can gain a level of functioning, confidence and independence which will improve her quality of life as well as her children’s.

Sarah was supported to apply for NDIS in July 2017 and attached to her application recent medical evidence to support her Mental Health/Disability diagnosis including:

- *Support/confirmation letter from her Psychiatrist*
- *Support/confirmation letter from her Clinical Psychologist*
- *Supporting evidence form from her GP*
- *ResSleep*

Sarah was rejected by NDIS stating she had not met eligibility requirements of Section 24(1)(b), Section 24(1)(e), Section 25 (1)(a) or Section 25(3). AnglicareSA supported Sarah to lodge an appeal, including further evidence of “permanency”, so she sought a letter of support from her treating psychiatrist for the review.

Despite the psychiatrist acknowledging and confirming Sarah’s diagnosis of Bipolar Disorder, Depression and severe anxiety, she refused to confirm that it was a permanent or a life-long disability, as this did not align with the principles of recovery within psychiatry, advising: “I will not alter my report which is accurate. Mental illness is not seen as permanent and lifelong”. AnglicareSA’s PHaMs team is still supporting Sarah. We helped Sarah lodge a review to NDIA in April 2018, and Sarah is still awaiting a decision. Sarah’s mental health has declined due to the additional worry of services ceasing and her continued ineligibility for funding through NDIS. Sarah states the toll of the constant pressure is affecting her through reoccurring depressive thoughts. Sarah will continue to be supported through Continuity of Support funding to re-apply for NDIS funding.

Inadequate continuity of support

The lack of ongoing funding for PIR, PHaMS or D2DL clients who are found ineligible for NDIS support mental health services is deeply concerning, given how far they already fall short of identified community need. Governments must be held accountable to their initial agreement that no one will be worse off due to transition to the NDIS.

Funding

We are concerned that the amount of funding likely to be provided for the continuity of supports will be below that previously provided for community mental health supports. This will not provide the continuity of support necessary for clients, and will not meet governments' commitment to no one being worse off.

We recommend to the Commission Anglicare Tasmania's submission to the Tasmanian Government Budget consultation 2019, which provides detailed analysis of PHaMS and PIR data and anticipated funding requirements to meet these needs⁶⁷.

Continuity of supports services for those ineligible for the NDIS should be maintained at a level equivalent to PHaMS funding, to maintain level of service and ensure the Governments' commitment that no-one is worse off. Anglicare Tasmania's analysis of current PHaMS costing shows the average cost of maintaining a low-level relationship with clients who are not eligible for NDIS psychosocial support is \$2,500 per year. This level of funding would enable clients to stay connected either on an ongoing or short-term basis to manage their mental health, maintain relationships with family, friends and their communities and to participate in education and employment. This is considerably less investment than the average NDIS package of psychosocial support costs (\$52,000) and would be considerably less than those same clients accessing acute mental health services as their first port of call. Providing such community-based support for those for whom the NDIS assessment process is currently unpalatable, for those who do not currently reach NDIS thresholds and for those who do not have a clinical referral is a relatively small investment compared to either NDIS support or the costs of providing acute services.

Eligibility criteria barriers

The psychosocial support services now commissioned through the Primary Health Networks (PHN) require a referral. We are concerned for clients previously accessing community based mental health services who do not have a clinical referral, and so are likely to be ineligible for these support services.

Further, we are concerned that current PHaMS, PIR and D2DL clients who have declined to have their eligibility for NDIS funding tested will have no entitlement to the Continuity of Supports funding. Clients may be reluctant to be tested for a range of reasons. These may include:

- not identifying as having a 'permanent' disability, as their illness is episodic;
- not being at a point in their mental wellbeing where connecting with a formal application, assessment and planning process is possible for them to contemplate; and
- A lack of understanding or scepticism about the benefits of an NDIS package.

The increased eligibility requirements for PHN funded supports and NDIS supports mean that many people previously accessing community mental health supports will be left without services, with ramifications for their own wellbeing, connections with others and engagement with other services.

New clients

It is unclear how people experiencing mental illness and seeking support for the first time after 1 July 2019 will access community-based supports, particularly where those clients do not wish to participate in the NDIS approach to funding and support, or are deemed ineligible for this. While people may have community-based support needs that are significant and urgent, they will not be eligible for Continuity of Support measures as existing PHaMs, PIR or D2DL clients, and will be either ineligible or not assessed for psychosocial support through the NDIS. This will leave a proportion of newly presenting clients living with severe and episodic mental illness with no access to supports. Anglicare Tasmania has estimated this may be the situation for around 162 clients a year in their region, based on extrapolating the proportion of non-clinical referrals to PHaMs and PIR.⁶⁸

Improvements needed in NDIS model for psychosocial disability

For people with psychosocial disability who have been successful in applying to the NDIS, there are still gaps in the service model. Poor assessment by the NDIA often results in no or low support available to people with psychosocial disability in their NDIS plans for daily living support. This means a lack of support for day to day essential living requirements, such as medical appointments, shopping and cooking assistance, household cleaning, budgeting, scheduling inspections, managing relationships with landlords, hygiene and personal care.

Further, many organisations have discontinued providing such daily living support services as the price set by the NDIA is simply unfeasible. This includes a number of Anglicare Australia members. The unfeasible price guide and withdrawal of services means participants have reduced choice and supports available, and places many clients at higher risk without access to these supports.

Increased risk of homelessness for people with complex needs

The change of service models with the NDIS has placed people with severe and complex mental illness who are unable to advocate for their own support needs at much greater risk, where they are unable themselves to navigate and use their NDIS funding. This results in increased vulnerability, deterioration of physical and mental health, higher risks to the community, and increased risk of housing eviction/homelessness, ED presentations and long hospital stays, and crisis support needs.

In South Australia, providers of Supported Residential Facilities (SRF) have supported people with exceptional needs (including severe and complex mental illness) to access safe and suitable accommodation. However SRF residents are now facing a risk of eviction as they cannot cover the cost of loss of the Government Board and Care Subsidy and increased service costs. SRF

residents with very complex needs and who are very vulnerable with limited or no family support are at significant risk of homelessness.

SRF clients may not have adequate independent representation to support their decision making as to how their NDIS funding is used. There is concern across the sector that some SRF residents may have no choice and control over which provider they go with once they have been accepted into the NDIS, as proprietors have self-appointed themselves as residents' representatives for implementation of NDIS Plans.

Continued funding to support independent advocacy and case management services which support people experiencing extreme vulnerability to remain engaged with the NDIS is needed to ensure the safety and wellbeing of individuals, assurance of customer choice in service and the best use of health and social support system resources.

Carers missing out under NDIS

Under block funding arrangements, carers haven't been able to access Department of Social Services funded Mental Health Respite Carer Support (MHRCS). Through these services, carers are able to contact service providers who they have an established relationship with directly, and receive support services for both themselves, the care recipient and other family immediately. For carers whose care recipient has been given an NDIS Plan, the carer becomes immediately ineligible for Mental Health Carer support. This creates a loss of social and educational support for carers, unless the carer is willing and has the capacity to pay for this service from their own personal finance. Generally, this is not a viable option for carers who are often on low incomes or Centrelink payments. On the provision of an NDIS Plan, Carers also experience a loss of access to financial support such as transport allowance.

At times Carers require the support of a crisis community support response, for example if the care recipient's behaviour changes significantly, or if the carer or their care recipient's health or support needs change rapidly. Where a Care recipient has an NDIS Plan, providers are unable to provide this type of crisis response to carers, leaving carers at risk of isolation, mental illness and family breakdown.

Carers of people living with mental illness (from mild episodic illnesses to severe and complex illnesses) must have access to ongoing, easily accessible, tangible supports that promote social inclusion, peer support, personal wellbeing, provide a soft place to fall when crisis occurs and inclusive information and advocacy. Carers rely on consistent underlying supports that support the functioning and wellbeing of everyone involved in the family/caring network, including the carer, care recipient, children and any significant others.

For people caring for adults with severe and complex mental illness, the caring role is generally around the clock. Decline in the carers' mental and physical health, increasing social isolation and carer burnout are a high risk and besides the decline in carer's wellbeing, also means care recipients are at greater risk. Appropriate supports for carers to maintain their own wellbeing, and enable their caring role, are crucial in supporting the participation and contribution of everyone and the sustainability of our social support network.

Recommendations

- Community-based mental health services such as PHaMs, PIR and D2DL must receive adequate and sustainable ongoing funding, to meet current and known unmet demand. This is a matter of highest priority given the uncertainty of funding arrangements and options for new clients post July-2019.
- It is critical that these services are not required to secure a formal diagnosis or referral for clients, as it acts as a significant barrier to people seeking or continuing to access support.
- Case management for people with highly complex needs and for example at risk of homelessness must be funded to assist them to navigate the NDIS.
- Funding for the Mental Health Respite Carer Support program needs to be urgently re-instated to provide vital support to carers, who are themselves typically vulnerable due to low income and managing support for their loved ones with mental illness.
- NDIS packages for psychosocial support should be systemically and rapidly reviewed to ensure proper funding for daily living support.

Aged Care

Please note that as this section has been provided separately to the Productivity Commission in confidence.

Conclusion

This inquiry comes at a time of large and persistent unmet need for mental health services in Australia; and significant disruption to service models due to the introduction of the NDIS. Fundamentally it offers us an opportunity to take a strengths-based approach to rebuilding our approach to mental health, and providing services to those who are mentally unwell. The risk is, after years of ducking the need to invest properly in Australia's mental health, governments will view the failure as too big to remedy in a systemic manner – because they fear the cost. Anglicare Australia sees this risk manifest in the language governments use when describing critical essential services we expect the state to provide us in order to build a good society. Governments talk of the *burden* of mental illness to our economy, the *cost* of providing our elderly with decent care, and the *burden* of the unemployed on the budget. We believe the Commission must challenge and seek to influence a reset of this language and mindset. The mental wellbeing of Australians should not be weighed up as a cost, and valued only in economic terms. This limits the capability of us all and narrows the vision of a good society for us all.

The good news is, community-based mental health systems built around early intervention and a recovery-based model get the best outcomes for people, and are affordable. Our submission, and separate complimentary submissions from our members The Samaritans, Anglicare NT, Anglicare Sydney, Anglicare Victoria and The Brotherhood of St Laurence, provide consistent documentation of the value (in all senses) of this approach and the core principles for creating a framework for effective mental health systems in Australia.

We have also included a series of recommendations for improving other critical systems that impact on people with a mental illness throughout this submission. They show that when a strengths-based approach is paired with a holistic government understanding of how other major policy settings can build mental wellbeing and resilience in our society, we can provide truly universal and successful mental health services in Australia.

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