

# Submission regarding the Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health

April 2019

Australian Red Cross is committed to improving the wellbeing of those experiencing extreme vulnerability. As an organisation committed to walking alongside Aboriginal and Torres Strait Islander communities to support improved wellbeing and achieve reconciliation; to meeting the humanitarian needs of migrants in transition; to supporting Australians to prepare for, respond to and recover from disasters; and to improve outcomes for those who are involved in the criminal justice system, we are acutely aware that the effects of mental health concerns can reverberate through all facets of life.

In reviewing the Productivity Commission's scope for this inquiry, we have determined that our experience working with diverse communities across Australia best positions us to respond to the following components of the scope:

- Examine the effects of supporting mental health on economic and social participation, productivity and the Australian economy;
- Examine how sectors beyond health, including education, employment, social services, housing and justice, can contribute to improving mental health and economic participation and productivity; and
- Examine the effectiveness of current programs and initiatives across all jurisdictions to improve mental health, suicide prevention and participation, including by governments, employers and professional groups.

Our submission reflects the voices of the communities and individuals we work with across Australia and is framed around what people living with mental health concerns have told us their lives are like and how other systems have an impact on their mental health. Throughout we make recommendations about how the system could be improved. Our report cannot and does not replace the direct voices of mental health consumers, however, our approach aims to acknowledge that people living with mental health concerns are the experts of their own lives. It also reflects the wide-ranging causes and effects for mental health concerns. The stories throughout this submission have been de-identified.

We thank the Productivity Commission for considering our submission. If there are any questions or you would like to discuss our submission further, please contact me

Yours sincerely

Kerry McGrath

Director of Community Programs, Australian Red Cross

## Summary of Recommendations

### DEVELOPING SUPPORTS IN PARTNERSHIP WITH PEOPLE WITH LIVED EXPERIENCE

1. That all mental health policy and practice is human centred, flexible and developed in partnership with people with lived experience.
2. That arrangements to permanently embed ongoing and active co-design with consumers and carers in all areas of policy and oversight, development of models of care, service and program reform, and evaluation are implemented.

### SOCIAL PARTICIPATION

3. That, recognising the importance of social connection and growing prevalence of loneliness, community based co-designed solutions to increase connection to support people living with mental health concerns are central to any response to enhance mental health. These should be developed in collaboration with the mental health system and resourced as part of broader mental health system reforms.
4. That access to transport and other practical support including using public transport is considered in any response to enhance mental wellbeing. This should include not only transport or access to mental health services, but also to avenues for social connection.

### STIGMA AND DISCRIMINATION

5. That the value and expertise of peer work is recognised as a way to improve support experiences and as a mechanism to reduce stigma through growing awareness, respect and value of lived experience of mental health concerns.

### FRAGMENTATION IN THE SERVICE SYSTEM

6. That reforms to the mental health service system focus on aligning the various stakeholders and include shared outcomes for all elements of the system.
7. That a mechanism to provide appropriate and adequately resourced psychosocial supports is developed beyond the current initiatives being administered through the Primary Health Networks.

### CRIMINAL JUSTICE

8. That in recognition of the substantial social and economic costs of incarceration or involvement in the criminal justice system, significant investment is made to address mental health concerns of people involved in the criminal justice system. This should include people in incarceration who are sentenced and unsentenced.
9. That prison mental health services are resourced to meet demand, including to provide transitional support to manage mental health concerns as people leave prison.

10. That existing community based mental health services are resourced and provided access to people in custody in a case coordinated approach to better plan for supports required upon release.

## **HOUSING**

11. That targeted supports for people living with mental health concerns impacting on their capacity to secure and maintain housing are implemented. These services should respond to demand flexibly to the episodic nature of mental illness.
12. That an integrated, joined up approach to housing and mental health supports is developed, with capacity to address other issues, such as substance abuse, gambling and financial wellbeing.

## **CHILD PROTECTION**

13. That specialised mental health services are provided targeting people at risk of becoming involved in the child protection system. These should ideally commence at pregnancy and be available intensively and for a long-term period (approx. two years) as required.

## **EMERGENCY RESPONSE**

14. That investment in the mental health impacts of disasters and community traumatic events is made in the elements of preparedness, response and recovery
15. That, in order to enhance the mental health and psychosocial wellbeing of people experiencing disasters, the Inter-Agency Standing Committee 'Guidelines on Mental Health and Psychosocial Support in Emergency Settings' are implemented throughout all Australia disaster response activities

## **MIGRATION**

16. That the mental health impacts of prolonged uncertainty for Temporary Protection Visa and Safe Haven Enterprise Visa holders are addressed through access to appropriate substantive visa pathways.
17. That people seeking asylum in Australia waiting on visa outcomes are afforded better access to specific (e.g. Status Resolution Support Service) and mainstream support services that meet their needs, including specialised mental health supports.
18. That, given the known deleterious impact on mental health, immigration detention is used as a last resort, for the shortest time possible and only after all alternative measures, including residence determinations/ detention in the community, have been exhausted

19. That, in order to address the significant negative impacts of separation, family reunification, for refugees, and humanitarian entrants in particular, is expedited.

**ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES**

20. That Aboriginal and Torres Strait Islander communities are empowered and resourced to develop their own culturally appropriate responses to mental health and wellbeing.
  21. That recommendations provided by Aboriginal and Torres Strait Islander controlled organisations are privileged and positioned to support self-determination with regards to enhancing mental health for First Nations people.
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## **What we have heard – the consequences for people experiencing mental health concerns**

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Australian Red Cross (Red Cross) works with communities across Australia and with many of Australia's most vulnerable people experiencing hardship and adversity. Across all of our work we are confronted with the impacts of mental ill health. We are also a provider of the Personal Helpers and Mentors program (PHaMs) and Partners in Recovery program, which give deep insight into the lives of people requiring psychosocial support across the country.

To better understand the needs of our clients, and in response to the reforms occurring as result of the introduction of the National Disability Insurance Scheme, we conducted a 12 month co-design process to understand:

*- How can we develop innovative service concepts that address and resolve social exclusion amongst people experiencing mental ill-health so that they can live connected, meaningful lives as part of their communities?*

This process took us to three regional communities to speak with over 250 consumers, carers, volunteers and other service providers to understand the experiences of those living with mental health concerns and understand what good support looks like. The insights we gained through this process inform this submission.

Our engagement with consumers, carers, volunteers, family members, peers, peer workers and other stakeholders gave us a deep insight into the challenges faced by people with mental health concerns. They provided a human voice and connection to lived experience and allowed us to build insight into the aspirations and challenges of people living with mental health concerns, their supporters and carers.

Participants in the co design process told of how their mental health concerns affects all aspects of their lives – including their ability to participate in the paid workforce and community life. They told us of the personal cost of experiencing mental health concerns – the intangible costs of loneliness, stigma and discrimination, and lack of independence. This section details the key insights that people living with mental health concerns have told us.

### **Developing supports in partnership with people with lived experience**

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*“This (co-design) turns us into individuals”*

*“In that listening, people begin to have hope”*

*“Who knows better of what the needs are than the consumers”*

Human-centred approaches need to be central to mental health policy and approach. Engaging with people with mental health concerns to understand their strengths, aspirations, problems, goals, needs and behaviour is the only way that we can successfully develop effective supports.

This approach is also relevant for Aboriginal and Torres Strait Islander peoples and communities to improve outcomes in mental health and achieve reconciliation by recognising and honouring the wealth of knowledge, strength, resilience and culture in our First Nations people.

## RECOMMENDATIONS:

1. That all mental health policy and practice is human centred, flexible and developed in partnership with people with lived experience.
2. That arrangements to permanently embed ongoing and active co-design with consumers and carers in all areas of policy and oversight, development of models of care, service and program reform, and evaluation are implemented.

### Lower social participation

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*“When you are broken, you may as well be in the desert, you are isolated.”*

Overwhelmingly, people living with mental health concerns told us that whilst clinical supports were essential to recovery and living a good life, so too was having people they could reach out to for support or just connection.

In considering the effect of mental health on economic and social participation, we emphasise the importance of healthy social connections. Our work with communities across Australia demonstrates consistently the value of strong social networks as a protective factor in preventing a person from developing mental health concerns, and that these networks are an essential part of recovery.

Healthy social networks and connections provide a safety net when mental health concerns fluctuate. People can access practical support (such as help getting to appointments or reaching out for help), as well as the intangible benefits such as having someone to speak to during difficult times, or knowing that there is someone who cares.

However, for those who live without such supports, a period of mental ill health can mean complete social isolation. This can be a temporary period of isolation, or persist and contribute to further decline in physical and mental health and increase recovery time. Such effects are not just harmful for the individual experiencing it, but carry significant economic costs to the health system.

#### **Activating communities to help people thrive**

The value of community and social networks is central to enhancing mental health and wellbeing, and thereby, to reducing the social and economic impacts of mental ill health.

Despite this, we often see that clinical mental health supports operate separately from community based mental health supports and broader community supports. There is an opportunity to integrate social and community capital to enhance mental health outcomes.

*“I just want to be in a safe community”*

*“You need to surround yourself with people. The right people.”*

#### **Challenges of consumer driven markets**

Whilst consumers of mental health services recognise the many benefits of the current mental health service system, social support services and mental health support services are often disconnected, if available at all. Further, the onus is often on consumers (or their families or carers) to navigate and advocate for supports. This is problematic not only because it places an undue burden on people experiencing mental distress, but it is also at odds with the need of consumers for proactive pathways into supports.

*“When you need help the most, you don’t want it”*

*“When I’m well, I have no problems reaching out, that’s not when I need help most though”*

The reforms to the system including the introduction of the National Disability Insurance Scheme (NDIS) are exacerbating some of these concerns. As much of the mental health service system moves to individualised funding models, the capacity of the psychosocial support providers to offer social support activities is diminishing. For example, as a PHaMs provider in many locations, we provide social activities such as coffee mornings or group activities for PHaMs clients in addition to individual case management and support. These group activities can be the difference for some people between a week alone, and a week with social activity. Whilst we support the introduction of the NDIS and the associated consumer empowerment, the service system risks losing invaluable social infrastructure which will impact on the most vulnerable.

Relationships with providers, workers and volunteers are also essential in order to promote social connection amongst people living with mental health concerns. Building trust and rapport are vital elements of our work and are often resource intensive. The ability for providers to invest this time and energy under the NDIS is limited which could lead to further isolation.

*“I want to know people first before I talk to them”*

The experience of Demi\*, a PHaMs participant demonstrates the issues associated with social isolation and consumer driven markets. It also speaks to the challenges surrounding NDIS eligibility for many people living with mental health concerns.

#### **Demi’s story**

*Demi is a 60 year old woman living with formally diagnosed depression and anxiety. As a young girl, Demi was taken from her parents’ home and placed in a state run children’s home. Later in life Demi experienced domestic violence where threats of burning down or blowing up the house were frequent and Demi’s actions and whereabouts were closely monitored by her ex-partner. As a result of her experiences in the state run residential facility and with her ex-partner, Demi struggles to engage with and trust new people. She also finds it difficult to communicate and assert herself, and at times finds it hard to leave her house. Demi has a limited social support network and is socially isolated and lonely.*

*Demi lives alone in a small town that does not have a mental health service and she does not drive. She relies on a public bus and car service to take her to a town 43 km away so she can access her GP and mental health nurse as part of her current Mental Health Plan. The mental health nurse is often so busy that Demi cannot see her for up to six weeks.*

*Currently her PHaMS support worker visits Demi in her home and this is her only access to mental health services locally. This helps Demi to cope in between her appointments with the mental health nurse. Demi is often overwhelmed by her depression, anxiety, and loneliness. She is not well equipped to take a proactive consumer role to understand what she is eligible for and how to access it under the user choice reforms, let alone being able to strongly self-advocate.*

*Demi is unlikely to be eligible for an NDIS individualised funding package on the basis that her psychosocial disability is episodic in nature. Funding for the service that Demi currently receives will be withdrawn as the NDIS is implemented and Demi cannot afford to pay for a similar service even if it were available.*

*Demi is also approaching the cut-off age for NDIS and she may have to access assistance through the aged care system. Given her limited social supports, she is likely to have difficulty understanding how to navigate this system and to negotiate effective supports for her mental wellbeing.*

### **Barriers to social participation and connections**

In many locations, positive places and ways to connect with people can often be hard to find, access, or feel a part of. Feeling unwelcome or judged prevents people from being themselves, which makes it hard to connect with others. In many locations, social activities are centred on social drinking which can be challenging for people who are managing substance abuse problems.

*“It’s hard to meet people when you don’t drink any more. I don’t want to drink anymore... I don’t want to get dragged back”*

*“I would like to meet more people. I just don’t want to have to go to the pub to do it”*

Similarly, the focus on sports or other mainstream mechanisms to social participation can have the effect of further marginalising people experiencing deep social exclusion.

*“There are lots of groups around for retirees but nothing for the in-betweens”*

The capacity for some to participate in face to face social activities can also be limited. Not only do many people live with mental health symptoms or conditions that prevent them from leaving their home, for many access to transport is out of reach.

Consumers have told us that opportunities for digital participation can play a role to increase social connection but do not replace the value of face to face communication.

*“On my worst day, I’d lock myself at home – but I might call or use a website”*

Finally, people living with mental health concerns consistently emphasise their desires to be not just a recipient of social inclusion activities, but to also contribute. Recognising the skills that a person has (big or small) that are valuable to others and using them can be powerful in empowering people living with mental health concerns.

*“The ability to give, no matter how small, and being supported to do that”*

*“It’s like a drum beat – it builds up your confidence and gives you the skills”*

*“The option to choose when and how to engage is empowering and facilitates independence”*

## **Loneliness**

Closely linked to the importance of healthy social connections, Red Cross is concerned about the increasing prevalence of loneliness. The experiences of poor mental health and loneliness are connected. A person can feel lonely as a result of their mental ill health (because they may be unable to participate in social activities), equally, feeling lonely can have a detrimental effect on mental health.

Through survey and analysis Red Cross has identified key insights relating to the experience of loneliness:

- Loneliness does not discriminate - More than 50% of Australians experience loneliness, and more than 80% think it’s getting worse. Young people are at greater risk of experiencing loneliness, with increasing loss of social connections and significant life transitions and disruptions.
- Mindshift of people to networks - It is well established that loneliness can be contagious through social networks, equally healthy social connection and ‘repairs’ to connection disruptors can be solved through networks. This requires a shift from individual relationships to understanding and valuing the health of your overall social network as well as your deepest bonds.
- Transitions are triggers - Life and social role transitions trigger up to 45% of experiences of loneliness. These transitions often reduce access to the easy, unavoidable, everyday interactions, and they are usually visible to others in a social network.
- Loneliness is a signal - Loneliness is a subjective feeling and a signal to connect with people (like thirst is a signal to drink water). We all want satisfying connections – loneliness occurs when these expectations are not met. Many of us respond to this signal, for those who don’t loneliness can increase the risk of early death. It is comparable with smoking 15 cigarettes per day and increases cardio vascular disease and premature death.
- Chronic, deep and clustered triggers - Over time, loneliness becomes a habit and it’s easier to do nothing. Loneliness is an important signal, but very few know what action to take. Additionally, many individuals and communities face additional disruptions and risk factors. This includes a number of high risk groups including people living with disability, mental health concerns, chronic conditions, older people, males, new parents, migrants.

## **RECOMMENDATIONS**

3. That, recognising the importance of social connection and growing prevalence of loneliness, community based co-designed solutions to increase connection to support people living with mental health concerns are central to any response to enhance mental health. These should be developed in collaboration with the mental health system and resourced as part of broader mental health system reforms.

4. That access to transport and other practical support including using public transport is considered in any response to enhance mental wellbeing. This should include not only transport or access to mental health services, but also to avenues for social connection.

## Stigma and discrimination

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Despite efforts to address stigma and raise awareness of the impacts of mental health concerns, many people feel ashamed of their condition and experience discrimination. Stigma and discrimination based on a person's mental health contributes to social isolation, the ability for people to seek help and access services and participate in paid or voluntary employment.

*"I don't like to judge people, people judge me though"*

People with mental health concerns often feel that others can't see further than their diagnosis or the symptoms they experience when unwell. Without understanding and empathy, building a collective sense of accountability for the wellbeing of everyone is difficult.

*"I was told on numerous occasions I love playing the victim"*

*"My mother... she doesn't believe in depression"*

### Barriers to seeking help

We see the effects of stigma and discrimination associated with mental health in our work around the country. A belief that people will be judged because of their mental health concerns can prevent people from seeking help either through clinical and community-based supports, or informally through their familial and social networks. Many people prefer to access supports or information that is non-specific to mental health. For some, the labelling of services, places, groups or activities as 'mental health related' can be a deterrent to attendance.

The experiences of Louise demonstrate the effects of stigma on people seeking help for mental health concerns.

#### Louise's story

*Louise is in her thirties and has both physical and mental health conditions that impact her ability to live the meaningful life that she desires. She experiences suicidal ideations, paranoia, delusions, depression and anxiety with comorbidities of drugs and alcohol abuse. She experiences chronic pain every day and this has exacerbated her depression and suicidal thoughts.*

*She has no formal diagnosis of her mental health however has made multiple attempts over the course of her life to engage with mental health services in order to receive the treatment and care that she requires.*

*Louise has experienced a significant amount of trauma from the stigmatizing attitudes and behaviours provided by health professionals and other agencies in institutional settings over the years. This has resulted in her rejection of mental health services, decreased the likelihood of her*

*seeking help during times of crisis, increased her psychological distress, and impacted her adherence to further treatment and support.*

*Louise describes mental health services and agencies with having an agenda and believes she is not seen as a person, but rather someone that needs to be labelled as the 'schizophrenic person' or the 'depressed person'.*

*Because of this, Louise has been unable to obtain a formal diagnosis nor receive the treatment for her mental health concerns. When she presents to her GP, she feels that her physical issues and pain she experiences are not taken as seriously due to having depression and anxiety, as well as contributing drug and alcohol factors. She has developed mistrust in mental health services and 'the system' because of negative experiences she has had in the past. These negative consequences have contributed to an increase in her suicidal ideations and feelings of isolation.*

### **Impact on employment**

Similarly, the effect of stigma and discrimination can limit a person's ability to communicate their mental health concerns in the workplace and request the support they need. This can lead to people leaving the workforce and the associated economic and social consequences of unemployment, as experienced by Charlie.

#### **Charlie's story**

*Charlie has lived a life of trauma, neglect and homelessness. At age 25 he was imprisoned due to theft around his gambling and substance addiction. Upon release he became a PHaMs Employment Participant, he worked hard to learn and use strategies to maintain both his mental health and sobriety. He engaged fully in groups and one to one peer work. He gained housing, improved relationships and standing within his family, he also gathered a new peer group around him which led to a loving relationship.*

*He had been unemployed for three years before he felt confident enough to start applying for work in his trade, and he was supported in this through both PHaMs Employment and his Disability Employment Services provider. After a lot of effort and persistence he secured employment.*

*To begin with he was elated and enjoying working again and all the benefits it brings. However, the manager of the company had little empathy or understanding around the regular appointments he had to keep with his mental health team in order to sustain good mental health. His manager also provided no support around making adjustments to his duties when Charlie was undergoing medication changes. Charlie said that he felt 'belittled' and anxious whenever he had to approach his manager and self-advocate around these things. This led to him forgoing his mental health appointments, rather than keep putting himself through the stress of asking. The employer also added to this anxiety by not being regular with wages, and routinely changing his roster at the last minute.*

*Charlie found that within the culture of the workplace it was not encouraged to speak about 'feelings', in fact it was ridiculed and he felt isolated, unsupported and stigmatized. Eventually it became too stressful for him and he was let go for absenteeism. This impacted heavily on his self-*

*esteem and confidence, he described feeling re-traumatised. Charlie relapsed, lost his housing and relationship.*

### **Value of peer work**

The growing prevalence of peer workers and recognition of their unique and valuable expertise is one powerful mechanism to provide more empathetic support experiences and to combat stigma and discrimination associated with mental health concerns.

The people we work with often speak about wanting to use their experiences to help others and those in peer worker roles speak to the satisfaction and validation that this work brings them.

*“Three years in a foetal position in my bed. Personal hygiene went out the windows, everything went out the window. It was my daughter and my peer worker who got me out of it”*

*“My peer worker was so supportive, she talked to me like a person, not a client”*

*“Becoming a peer worker has allowed me to look back, make sense of, and value my life experiences, both positive and negative. This in turn has lessened my shame and guilt. It’s allowed me to understand that all experience can be learnt from, and that sometimes sitting with discomfort is actually the way forwards for my recovery and is not to be feared. It can be hard work, however I couldn’t imagine doing anything else that would provide equal satisfaction, pride and hope”*

### **RECOMMENDATION:**

5. That the value and expertise of peer work is recognised as a way to improve support experiences and as a mechanism to reduce stigma through growing awareness, respect and value of lived experience of mental health concerns.

### **Fragmentation in the service system**

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Through our work we have observed that the mental health support system is fragmented and lacks a shared vision for outcomes. The current system often doesn’t make lasting, positive change for people with mental health concerns. We need to build flexible, collaborative and cross-disciplinary support by taking a holistic approach, and connecting with people in ways that build trust and provide continuity.

One of the major barriers to effectiveness of current approaches is the extensive fragmentation of services, policies and providers. The psychosocial support landscape in Australia has a mix of federal and state investment across multiple departments. This has been exacerbated by the introduction of the NDIS which adds further complexity. Managing the requirements of the various funders not only results in duplication and at times confusion in achieving a person centred flexible mental health system.

In addition, appropriate and effectively resourced psychosocial support services are currently lacking, particularly as a result of the current NDIS and Primary Health Networks (PHN)

implementation. It is unclear if the current Continuity of Support arrangements and the National Psychosocial Supports Measure implemented through PHNs will sufficiently meet demand when Commonwealth funding psychosocial support programs cease.

We highlight the work of the Mental Illness Fellowship of Australia regarding a nationally consistent, adequately resourced approach to providing psychosocial supports. Such an approach would deliver individual and group orientated psychosocial supports with carer support services, assertive outreach and stepped care options delivered through a person centred approach. This approach could integrate the existing commitments for Continuity of Support for clients of Commonwealth funded psychosocial support programs, and the National Psychosocial Support Measure to provide a cohesive and integrated approach to the provision of psychosocial supports.

#### **RECOMMENDATIONS:**

6. That reforms to the mental health service system focus on aligning the various stakeholders and include shared outcomes for all elements of the system.
7. That a mechanism to provide appropriate and adequately resourced psychosocial supports is developed beyond the current initiatives being administered through the Primary Health Networks.

### **How other systems have an effect on people living with mental health concerns**

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Red Cross also works across a range of other sectors and service systems, as a result we have insights into the effects of mental health concerns for people across a range of areas. This section details our insights across the criminal justice, housing, child protection, emergency response, migration and Aboriginal and Torres Strait Islander sectors, and how these impact on people living with mental health concerns.

#### **Criminal justice**

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*“We empower everyone else... Why not ex-offenders”*

Red Cross interacts with people who have been or are involved in the criminal justice system through many elements of our work. This means that we confront regularly the well-documented link between mental health concerns and offending behaviours. The Australian Institute of Health and Welfare’s report on the health of Australia’s prison population<sup>1</sup> found almost half of prison entrants report experiencing mental health condition/s.

Our experience working with people involved in the criminal justice system also indicates higher rates of mental health concerns. One of our post release services in New South Wales has found that:

- 60% of active clients had diagnosed mental health at initial intake;
- 90% of active clients have a disability (not limited to psychosocial disability) – includes diagnosed and undiagnosed at intake and then substantiated through further assessment; and

- 100% of active clients have cognitive and/or diagnosed mental health conditions (the most common diagnosis being depression, anxiety, paranoid schizophrenia, bipolar, borderline personality disorder, acquired brain injury and foetal alcohol syndrome).

The effect of this over-representation of mental health concerns is a contributor towards offending behaviour and incarceration, with the effect of incarceration or experiences compounding a person's mental illness that led to a person being incarcerated. The experience of incarceration can also be a contributing factor to a person developing mental health concerns.

The overrepresentation of people living with mental health concerns in the criminal justice system is a stark indicator of the social and economic costs of mental illness and demonstrate the inequity of our current criminal justice system.

*“Prisoners are two to three times as likely as those in the community to have a mental illness and are 10-15 times more likely to have a psychotic disorder. Our research suggests that one in three people taken into police custody are likely to be receiving psychiatric treatment at the time. If you include those with a substance misuse disorder, the numbers increase even further”* - Professor Ogloff, Professor of Forensic Behavioural Science, Director of the Centre for Forensic Behavioural Science at Swinburne University of Technology<sup>ii</sup>

Involvement with the criminal justice system can be traumatic and require significant support and assistance in order to rehabilitate. This is especially relevant for people with mental health concerns.

In our experience, the best supports are intensive and often begin before a person leaves prison. It takes a significant amount of time for workers to develop rapport and trusting relationships with clients, many of whom have had negative experiences with service systems previously. Commencing engagement in custody can also leverage the benefits of routines developed in prison (safe housing, meals, medical treatment, etc.). Given that many people leave prisons to go back into chaotic lives, for some, this can be the prime opportunity to start a support or medical intervention.

Post release supports are also lacking within the current system. We work with people who are released often without basic things such as medication they have been taking to manage their mental health concerns or suitable housing. Significant time and advocacy support is required to help people navigate the service system post release and access the supports they need (mental health or otherwise). This support is particularly relevant for people with disabilities given the significant and well documented access challenges associated with the NDIS.

The experience of John demonstrates some the challenges people with mental health concerns confront when leaving prison.

### John's story

*John was released on the weekend without being given his medication despite a prescription prepared for discharge because the casual weekend prison staff were unfamiliar with procedures and John's specific needs. This meant that John was without medication for almost four days. Eventually John was referred to Red Cross by a Mental Health Nurse who was concerned that the period without medication could provoke a psychotic episode.*

*John was supported to access a GP and recommence his medication but without such involvement it is likely that John's condition could have declined to the point where he experienced a psychotic episode which may have led to him engaging in risky behaviours or re-offending.*

Lack of access to housing upon release from prison can exacerbate a person's mental health concerns and maximise risk of re-offending. Peter's story demonstrates the importance of housing and mental health services upon release in order to support a person to successfully reintegrate to community and avoid vulnerable situations that might lead to further offending.

### Peter's story

*Peter has a history of mental health concerns prior to his incarceration. Whilst incarcerated he was treated for his mental illness (anxiety) and an assessment was made which identified that he also had an intellectual disability.*

*With support from Red Cross, Peter was able to move into temporary accommodation immediately after his release from prison, however this was limited to just 39 days. During this period, significant efforts were made by Peter and his Red Cross support worker to secure more sustainable housing. This included applications to 8 different boarding houses. Peter and his worker also attempted to find housing on the private rental market, however this proved to be unaffordable on a Newstart allowance.*

*Eventually after his temporary housing ended, despite best efforts to secure stable housing, Peter had to move into his broken down and unregistered car parked at a local park. Stable and secure accommodation is essential to Peter's rehabilitation and mental health recovery. Red Cross is assisting Peter to apply for the Disability Support Pension which would increase the amount of money Peter can spend on accommodation and hopefully enable him to move into stable accommodation on the private rental market, however in the interim Peter is at significant risk of not only re-offending, but also at risk of experiencing a decline in his mental health.*

There is also a need to improve access to mental health supports whilst people are in prison. Many of our clients are unable to access clinical mental health supports whilst incarcerated due to long wait lists. In one prison we work, there are no permanent clinical mental health supports,

only a visiting psychiatrist and psychologist. This means that people seeking mental health support are triaged and even the most severe needs often face wait times of up to a week which is insufficient, particularly for people experiencing psychosis.

Given the substantial economic cost of imprisonment (\$109,500 /annum for one person<sup>iii</sup>) as well as the substantial social and health consequences of imprisonment, addressing the mental health concerns of this group of people could yield significant economic and social benefit. A holistic approach to supporting the rehabilitation of people in prison that recognises the impact of mental health concerns and adequately resources treatment both in and outside of prison would better enable people upon release to reintegrate to the community, and reduce the likelihood of re-offending.

#### **RECOMMENDATIONS:**

8. That in recognition of the substantial social and economic costs of incarceration or involvement in the criminal justice system, significant investment is made to address mental health concerns of people involved in the criminal justice system. This should include people in incarceration who are sentenced and unsentenced.
9. That prison mental health services are resourced to meet demand, including to provide transitional support to manage mental health concerns as people leave prison.
10. That existing community based mental health services are resourced and provided access to people in custody in a case coordinated approach to better plan for supports required upon release.

#### **Housing**

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The link between homelessness and mental health concerns is well documented. Mental health concerns can both contribute to the likelihood that a person will experience homelessness and develop as a result of homelessness or housing insecurity. A person's mental health concerns can impact on their ability to maintain employment and financial security and housing and conversely, the absence of secure housing can make a person more vulnerable to mental health concerns.

Red Cross is a founding partner in The Constellation Project, a growing group of organisations collaborating across sectors in order to end homelessness in a generation.

Through this and our experience working with people experiencing mental health concerns, we see the impacts of the interaction between mental health concerns and homelessness.

#### **Cross-system supports**

In our experience, people living with mental health concerns can require additional support beyond the provision of accommodation to access and maintain housing. The nature of mental health conditions can mean that a person experiences times of wellness and decline. The provision of wrap around support is required during times of distress for a person to maintain safe housing regardless

of whether such housing is secured through the private rental market or subsidised housing. We also know that safe and secure housing is a key foundation for all people, regardless of their mental health, to be able to participate in the paid or volunteer workforce.

Despite this clear link between housing and mental health, the housing and mental health service systems often operate with silos. Both experience chronic over demand and have limitations in supporting a person living with mental health concerns to access and maintain housing.

The experiences of Sam and Michael demonstrate the factors impacting a person's ability to secure and maintain housing and the need for flexible, cross-system supports.

### **Sam's story**

*Sam\* is a young man who was supported through one of our regional PHaMs sites. After a challenging childhood including one absent parent and the other struggling with a gambling addiction, Sam developed drug and alcohol programs and himself began gambling. Ultimately Sam was imprisoned for burglary and he entered the PHaMs program upon his release from prison because whilst incarcerated he had been diagnosed with bi-polar disorder.*

*Sam was staying with family in this regional area which was a condition of his bail release, however the arrangement was untenable due to familial relationships and overcrowding in the home.*

*With support from his PHaMs worker, Sam was able to engage in AOD and gambling treatment programs, and also access emergency accommodation. From here, he was able to move into private rental accommodation and was able to meet the requirements of his release conditions.*

*Sam himself acknowledges that without the support of his PHaMs worker he would likely have been unable to make the progress that he did, and that safe, secure and stable housing was central to his rehabilitation and recovery journey*

### **Michael's story**

*Michael is a 34 year old single male with a schizophrenia diagnosis, who had low self-esteem and was hesitant to have contact with housing support workers. Michael was sleeping rough in his car, and always changing locations.*

*Michael was engaged with a Red Cross support service which assists people being admitted to, or discharged from Specialist Mental Health Inpatient Units who are homeless or at risk of homelessness to access and/or maintain long term stable accommodation. With assistance from his support worker, Michael was able to complete a number of support plans, discuss obstacles that were hindering him from obtaining safe and secure accommodation and work with his support worker to implement strategies to address these obstacles.*

*Once a property was available and offered to Michael that suited his self-identified needs, he accepted the property and has excelled in his engagement with the program. Through brokerage*

*funds, and his own funds, Michael was able to completely furnish his property. Michael maintains the property to a high standard and has taken a particular liking to improving the lawn and garden areas.*

*Due to having secure housing in an area that Michael feels safe and comfortable, his attitude and outlook continue to become more positive and his self-esteem is improving. Michael has found the confidence to start looking for longer term employment, as he had some seasonal employment for a short period of time and now feels that he is ready for part or full-time employment. Michael is continuing to work with Community Mental Health and was exited from the program after a period of 15 months.*

### **Undersupply and affordability**

Chronic undersupply in social and other affordable, safe, and appropriate housing options is another challenge in this area. Housing affordability and financial stress are at the root of homelessness<sup>iv</sup>. A recent report from the University of New South Wales's City Futures Research Centre has calculated how many homes are needed for low and middle income households, to reduce rising rates of homelessness and the numbers of people living in housing stress. Australia needs to build 728,600 social housing properties and 295,000 affordable rental homes over 20 years, to meet current demand and keep pace with population growth<sup>v</sup>.

### **RECOMMENDATIONS:**

11. That targeted supports for people living with mental health concerns impacting on their capacity to secure and maintain housing are implemented. These services should respond to demand flexibly to the episodic nature of mental illness.
12. That an integrated, joined up approach to housing and mental health supports is developed, with capacity to address other issues, such as substance abuse, gambling and financial wellbeing.

### **Child Protection**

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Child protection is another system that interacts closely with and is affected by the impacts of mental health concerns. Mental health concerns can develop as a result of an experience in or with the child protection system. Equally, mental health concerns can be contributing factors for a person becoming involved in the child protection system as a parent.

The costs of child abuse and neglect are well understood. A 2008 report<sup>vi</sup> estimated that the total cost of child abuse and neglect was almost \$4 billion per annum, with \$383 million for health alone. Mental health concerns, such as depression and anxiety, are estimated to account for approximately two thirds of the total health system costs.

Red Cross works with many families who have interactions with the child protection system including our direct work providing the Birth Parent Advocacy Service assisting families with children

involved in the child protection system, and in the Young Parents Program where we provide a residential and community based parenting support program for young parents whose children are at risk of entering out of home care.

A major challenge regarding the child protection system and the social and economic costs of mental health is access to mental health services, specifically, access to services that are therapeutic and appropriate for the complex needs many of the parents we work with have. Many young parents have complex needs, resulting from their challenging backgrounds or their experience of becoming a parent at a young age, highlighted by Sarah's story.

### **Sarah's story**

*Sarah is a 15 year old Aboriginal young woman. She was referred to Red Cross in November 2018. Sarah was pregnant at the time of the referral and entered a residential support service with her two month old, Joe in January 2019.*

*Sarah has a long child protection history beginning at age 3. Sarah entered into Out Of Home Care at age 12 and is now in her thirteenth placement. Sarah has experienced a childhood of significant stressors and abuse including emotional neglect, domestic violence, parental mental health issues (obsessive compulsive disorder, borderline personality disorder and bi-polar), and child-hood sexual assault. Sarah presented with a range of symptoms and behaviours including self-harming behaviours, symptoms of PTSD, difficulties in emotional regulation, history of absconding, lack of protective behaviours and sexualised behaviours with older men. She has also been the victim of incidences of sexual assault, one of which subsequently led to her pregnancy.*

*Sarah does not have a diagnosed mental illness. A re-assessment has been pending for 12 months, however has not been completed due to transience and placement disruptions. Sarah has a complex trauma history and displayed low trust, poor attachment, limited stress management abilities, low emotional regulation and recognition capacities, and difficulties in maintaining concentration.*

*When Sarah entered Red Cross' service referrals were made to a local private clinic of clinical psychologists that specialise in perinatal mental health for ongoing therapeutic intervention and management of any emerging mental health. Sarah was also referred to a local Headspace but was informed that Sarah's complex needs were too high for their model of care.*

*Upon entry to the service, Sarah was supported to engage with a local GP who prescribed anti-depressants. In a follow up appointment Sarah scored high on the Edinburgh Postnatal Depression Scale and was pre-scribed an anti-psychotic drug to help with sleep and agitation.*

*Referrals were also made to a number of other specialised mental health services however these were not accepted either because of the complexity of her condition, or because she did not meet other eligibility criteria such as not having a consulting child and adolescent psychiatrist. Her referral to a private clinic is yet to receive a response.*

*Red Cross continues to support Sarah and Joe, however without developmentally appropriate, attachment based, trauma-focused therapeutic intervention the opportunities for Sarah to develop parenting capacity and individual well-being is impacted greatly.*

**RECOMMENDATION:**

13. That specialised mental health services are provided targeting people at risk of becoming involved in the child protection system. These should ideally commence at pregnancy and be available intensively and for a long-term period (approx. two years) as required.

**Emergency response**

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Red Cross supports people to prepare for, respond to and recover from disasters and other significant emergencies and plays a key role in the broader emergency services sector. We also provide psychosocial and other supports in response to other traumatic events. Through this work we are acutely aware of the mental health effects of all types of emergencies and their effect of social and economic participation.

As a foundation member of the University of Melbourne's Beyond Bushfires research into the health and wellbeing trajectories of the Black Saturday Bushfires, we know that the experience of living through a disaster makes a person more vulnerable to mental health concerns. It can also exacerbate a pre-existing mental health condition either through the trauma of the event and in some instances can induce a post-traumatic stress response. The experience of a disaster can also effect a person's mental health in ways that can impact social and economic participation, for example through sleep disturbances, prolonged low mood and difficulty concentrating.

The Australian Business Roundtable for Disaster Resilience and Safer Communities (of which Red Cross is a member) estimates<sup>vii</sup> that the projected lifetime cost of mental health as a result of the 2010-11 Queensland floods is \$5.9 billion. The projected lifetime mental health cost of the 2009 Black Saturday Bushfires is \$1068 billion, with an additional \$193 million for risky or high alcohol consumption.

Despite these significant costs, investment in disaster resilience is often focussed primarily on infrastructure, with limited integration between health including mental health and disaster and emergency preparation.

Australia is not unique in confronting this challenge. The mental health impacts of disasters have been considered by the Inter-Agency Standing Committee including through the development of 'Guidelines on Mental Health and Psychosocial Support in Emergency Settings<sup>viii</sup>'. These guidelines were developed to support agencies involved in disaster response to deliver responses that protect and improve people's mental health and psychosocial wellbeing in the midst of an emergency. These set out both minimum and best practice response across a range of domains including coordination; assessment, monitoring and evaluation; protection and human rights standards; human resources; community mobilisation and support; health services; education; dissemination of information; food security and nutrition; shelter and site planning; and water and sanitation.

The experience of Pauline demonstrates the impacts that emergencies and disasters can have on mental health for some.

### **Pauline's story**

*One morning in January 2015 as she was watching TV, Pauline saw a story about a bushfire at Sampson Flat. She looked up the location and realised it wasn't far away from her home in semi-rural South Australia.*

*"We weren't terribly bothered because the first message we got was that it was contained and we went back to watching TV. The message kept scrolling and I thought, 'That's unusual'," she says.*

*"We went outside and saw huge plumes of smoke and I thought, 'That really doesn't look very good,' so we started to think 'Well, we can't defend the home from bushfire so we'd better pack up and leave.'*

*Pauline says from that moment, her life turned upside down.*

*She quickly had to make decisions about what to take and what she could sacrifice. She grabbed a change of clothes, toiletries, her pets and their necessities and then she and her husband evacuated. Luckily they had friends who offered them accommodation, but Pauline and her husband had to go to separate houses to find space for their large number of dogs and cats. She says being unable to support each other at that time greatly added to her distress.*

*As it turned out, they didn't suffer much property damage, apart from fencing and retaining walls, but nevertheless, Pauline says the worst part of the ordeal was how hard and how long she was hit emotionally. Arriving back home, she says she felt a combination of relief and overwhelming grief at how the landscape had changed.*

*"The area we live in is very pretty and just driving back into it and seeing everything black; I remember driving home and crying the whole way. "It's the realisation that bushfires do happen to you and can happen to anybody."*

*The next three months were a blur as Pauline and her husband worked day and night to rebuild and repair around the rural property, while also holding down full-time jobs.*

*"We were just absolutely exhausted. We had to go back to work and every spare minute we had we tried to put our property back to the way it was and we ended up emotionally and physically collapsing. For us, because we weren't prepared emotionally or psychologically, it was very hard. We had to take stock of what we can do and what we can't do and accept what we had."*

*Then, just when she thought she'd recovered, an incident at work at the six-month mark hit her all over again. "I overreacted to something, which was very out of character for me. I sat down with my manager and said 'I really don't think I'm actually coping'. I found I wasn't working as well as I previously had. I was forgetting things and not really coping with things that I easily coped with before. I tried to brush it off and say, 'The fire has gone, we're still lucky.' I was trying to help others in the community with greater losses than me but I wasn't coping."*

*Pauline says it took at least 12 months for her to recover emotionally, with the help of medical treatment, and the support of her husband and friends.*

*“It’s a very long process and you don’t really understand why you’re feeling that way. You don’t feel like you should be feeling depressed or anxious because you haven’t suffered like others. But you do. And then you feel guilty and it starts this whole cycle of guilt, anxiety and depression.”*

*Pauline is now in a community leaders’ group to encourage people to think about their mental and psychological preparedness for a disaster. “Your mental state is something people take for granted until you have to deal with a disaster. It really is important to prepare emotionally. I encourage people to think when they are watching the news and someone is going through an earthquake, bushfire, flood or cyclone, ask themselves: ‘What would you do if you were in that situation and how would you cope with it?’”*

## **RECOMMENDATIONS:**

14. That investment in the mental health impacts of disasters and community traumatic events is made in the elements of preparedness, response and recovery
15. That, in order to enhance the mental health and psychosocial wellbeing of people experiencing disasters, the Inter-Agency Standing Committee ‘Guidelines on Mental Health and Psychosocial Support in Emergency Settings’ are implemented throughout all Australia disaster response activities

## **People made vulnerable through migration**

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Since 1990, Red Cross has supported well over 50,000 vulnerable refugees, asylum seekers and other migrants who have overcome great challenges, fled situations of extreme violence, trauma, exploitation or great disadvantage, to ensure a safe future for themselves and their families. Many have also been and remain separated from their families.

Through this work and an ongoing longitudinal research study undertaken in collaboration with the University of New South Wales (the Refugee Adjustment Study)<sup>1</sup> we are acutely aware of both the incredible resilience of many but also the mental health needs of vulnerable migrants and the barriers to meeting those needs.

We have identified the impact of visa uncertainty, lack of access to services (including difficulties in navigating services and barriers due to a lack of cultural competency of services), family separation and prolonged immigration detention as having significant negative impact on the mental health for people seeking safety in Australia.

These factors can not only undermine people’s resilience and coping mechanisms but can also significantly impact on their ability to fully participate in and contribute to Australian society socially and economically.

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<sup>1</sup> The ongoing longitudinal Refugee Adjustment Study (RAS) conducted by the Refugee Trauma and Recovery Program at the School of Psychology, UNSW Australia in collaboration with the Australian Red Cross and Settlement Services International

## People seeking safety

*“After it [income support] ceased, we are living like beggars. That is damaging our self-confidence, especially for the kids, the young ones; they’re thinking that now we have to live like this the rest of our lives.”*

*“I just really want to be able to manage on my own.”*

Many people seeking safety in Australia have a complex experience of trauma, high prevalence of mental health issues<sup>ix</sup> and continue to live with profound uncertainty. This includes over 30,000 people seeking safety who are on an insecure visa status, because they are on Bridging Visa’s awaiting a visa outcome or on Temporary Protection or Save Haven Enterprise Visas.<sup>2</sup>

An increasing number of people seeking safety on Bridging Visas are falling through the gaps because they no longer have access to mainstream support services, including the federally funded Status Resolution Support Services as well as people who are not eligible for or are experiencing significant barriers to accessing Medicare.

As a result, we have supported more than 5600 people through our emergency relief (flexible funding and material support) since 2016 and observed that of vulnerable migrants accessing emergency relief:

- 72% have reported living with a mental illness required financial assistance to purchase essential medication in the 2016/2017 Financial Year.<sup>x</sup>
- 38% have reported not having their mental health needs met in the current financial year;
- Over 35% of people didn’t have work rights; and
- 61% are experiencing or are at risk of homelessness.

For those without access to government and other mainstream support, there is a significant risk of destitution, homelessness, exploitation or detention. These all further exacerbate people’s mental health concerns and reduce their social and economic participation.

## Impact of visa uncertainty

The longitudinal Refugee Adjustment Study, referred to above, has further identified that people seeking safety who are on insecure visa status have significantly higher rates of probable diagnosis for PTSD, Depression and Suicidal Intent than those with secure visa status as outlined in Table 1 below.<sup>xi</sup>

Table 1

Rates of Probable Diagnosis	Insecure VISA Status <sup>3</sup>	Secure VISA status <sup>4</sup>
PTSD*	49%	30%
Depression*	27%	7%
Suicidal intent*	8%	1%

<sup>2</sup> Note: This includes only people who arrived to Australia by boat since July 2012 and does not include people who arrived by plane and subsequently applied for protection.

<sup>3</sup> Including Bridging Visas, Temporary Protection Visas and Safe Haven Enterprise Visas

<sup>4</sup> Including Permanent Protection Visas, Permanent Residency and Australian Citizens

\*Significance test:  $p < .05$

The interim findings of the Refugee Adjustment Study highlight that people seeking safety with insecure visa status<sup>xii</sup>:

- Have had different experiences and have different needs to those with secure visas
- Have poorer mental health, but are not worse functioning, and have better social engagement
- Feel that a sense of security / permanence is important for well-being

### **Prolonged immigration detention**

Red Cross visits each immigration detention facility in Australia once per quarter to monitor the conditions of detention and the treatment of people in detention. This includes collecting information from people in detention, service providers and departmental staff on the mental health needs of people in immigration detention and their access to relevant services. Red Cross provides confidential reports directly to the authorities from these visits.

From our experience, backed by external research (see below), we know that prolonged immigration detention has significant and lasting mental health impacts that reduce people's social and economic contribution following their release either in Australia or return to their country of origin.

Based on publicly available information since June 2015, the average length of time people have been held in immigration detention has consistently been over 400 days. At the end of 2018, the period of immigration detention in Australia averaged an unprecedented 511 days, with half of the detention population (522 people) being held in detention more than one year<sup>xiii</sup>.

This is taking place despite the established knowledge that prolonged immigration detention has negative impacts on people's mental health, even after short periods of detention, and that these consequences extend beyond the time of release.

Numerous studies have demonstrated that:

- People in immigration detention experience poorer mental health than people with the same status who are placed in the community<sup>xiv</sup>; and
- People who are detained for more than one month experience a decline in mental health, with this decline continuing the longer they are in detention<sup>xv</sup>.

Immigration detention is also very expensive<sup>xvi</sup>. Annually, it costs:

- More than \$346,000 to hold a person in immigration detention in Australia;
- \$103,343 for a person to live in community detention in Australia; and
- \$10,221 for a person to live in the community on a bridging visa while their claim is processed.

### **Family Separation**

For over 100 years, our Restoring Family Links program has helped people to re-establish contact with family members who have become separated and/or lost contact due to conflict, war and

disasters. Since 2017, we also been supporting refugees to settle in Australia through the Humanitarian Settlement Program in WA, ACT and southern NSW.

Through this, we have long observed the impact of family separation on people's wellbeing through our work with refugees and people seeking safety.

From conversations with people seeking safety and refugees in particular, we know that continued family separation has a negative impact on their ability to fully establish their new lives in Australia, including their social and economic participation.

The above-mentioned Refugee Adjustment Study also includes data and initial findings on the impact of family separation on mental health supports our observations and indicates that for people (whether they are on certain or uncertain visa status) who are separated from family:

- Trauma exposure and post-migration stress is greater.
- Family separation is linked to worse PTSD/depression symptoms (but not reduced functioning).

The initial findings of the study substantiate the importance of family reunification for the mental health of people seeking safety and arguably for many other migrants.

Currently refugees and other humanitarian entrants experience significant barriers in being reunited with their family members including:

- Temporary Protection Visa and Safe Haven Enterprise Visa holders who arrived by boat without a visa after 13 August 2012 are not eligible to propose any family members;
- Refugees who arrived prior to 13 August 2012 are given the lowest priority for family reunion;
- Limited spaces for places for family reunion under the Special Humanitarian Program; and
- Prolonged waiting periods for people refugees and humanitarian entrants who are eligible to apply for family reunion.

#### **RECOMMENDATIONS:**

16. That the mental health impacts of prolonged uncertainty for Temporary Protection Visa and Safe Haven Enterprise Visa holders are addressed through access to appropriate substantive visa pathways.
17. That people seeking asylum in Australia waiting on visa outcomes are afforded better access to specific (e.g. Status Resolution Support Service) and mainstream support services that meet their needs, including specialised mental health supports.
18. That, given the known deleterious impact on mental health, immigration detention is used as a last resort, for the shortest time possible and only after all alternative measures, including residence determinations/ detention in the community, have been exhausted

19. That, in order to address the significant negative impacts of separation, family reunification, for refugees, and humanitarian entrants in particular, is expedited.

### **Aboriginal and Torres Strait Islander communities**

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Aboriginal and Torres Strait Islander people experience higher rates of mental health concerns than non-Indigenous people. The effects of intergenerational trauma, dispossession and disconnection from culture, economic and social disadvantage, physical health problems and many other forms of historical and ongoing systemic discrimination have contributed to poor mental health outcomes for Aboriginal and Torres Strait Islander peoples, and alarmingly high rates of suicide.

Recognising the importance of self-determination and community led solutions, Red Cross urges the Productivity Commission to take account of the submissions of Aboriginal and Torres Strait Islander controlled organisations.

Our experience working with Aboriginal and Torres Strait Islander communities has demonstrated to us the social and economic cost of mental health concerns and the impact this can have across generations. These are exacerbated in many instances by a lack of culturally appropriate services. Many of the people we work with, particularly in remote communities encounter severe shortage and limited access to mental health services. In one location, there is one visiting psychologist and one psychiatric nurse for a population of over 2500 people, many of whom have complex mental health and psychosocial support needs. When contrasted to the 1FTE psychologist per 963 people in major cities<sup>xvii</sup>, this inequity is stark. This community is serviced by some 'fly in fly out' supports however the lack of consistency has major impacts on the community and particularly people who are hesitant to engage with service systems.

Culturally informed mental health services can be even more difficult to access so many Aboriginal and Torres Strait Islander peoples are unable to access services that leverage the strength and resilience of Indigenous cultures in mental health treatment.

We see the strain on Aboriginal and Torres Strait Islander peoples who live and work in communities with complex mental health and other needs.

The story from one of our Aboriginal staff members demonstrates these issues.

#### **Callum's story**

*The biggest challenge is that we don't get a break from the issues of the community unlike outsiders whom are able to go home and away from the community. It seems like we are exposed to the issues and community 24/7, without the ability for self-care or to escape in order to recharge. Sometimes it's a good thing and sometimes it's not.*

*In community, mental health services are very limited and are not effective or efficient in a cultural context. So when community members are in these positions, the community will take full advantage to get supports from people with similar understandings of what challenges and barriers are for people in community. This puts a lot of pressure on mental health workers that live in community as we are seen as someone that hold some kind of status.*

*Also, due to the remoteness of the community, it is hard to get out to have a break to recharge or care for yourself. This causes a high rate of burnout of community-based workers. The only way to avoid burnout is to distance yourself from the sector or go to the extreme of moving out of the community for a period to recharge. This is not what is needed or what we as mental health workers want. We would like to stay in community with more opportunities to take breaks and care for ourselves.*

The introduction of the NDIS has exacerbated many of these challenges. Not only have transitional challenges increased service access uncertainty, particularly the Commonwealth funded psychosocial supports, in many remote locations the viability of a market driven scheme appears to be challenging. We are extremely concerned in some of the locations we work that NDIS service provision will not be viable and people will be unable to access the benefits of the NDIS.

In addition to challenges with the implementation of the NDIS, we see that many of the people we work with are extremely hesitant to engage with it. Many of the people we support are distrustful or nervous about engaging with government systems due to negative past experiences with government or services. Aboriginal and Torres Strait Islander people living in remote communities also do not generally have a strong understanding of the NDIS, and some are hesitant to adopt labels such as “disabled” or “permanently impaired” because of stigma associated with such terms and fear that there will be other effects on their lives should they access the NDIS.

#### **RECOMMENDATIONS:**

20. That Aboriginal and Torres Strait Islander communities are empowered and resourced to develop their own culturally appropriate responses to mental health and wellbeing.
21. That recommendations provided by Aboriginal and Torres Strait Islander controlled organisations are privileged and positioned to support self-determination with regards to enhancing mental health for First Nations people.

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- <sup>i</sup> Australian Institute of Health and Welfare (2015). *The health of Australia's prisoners 2015*. Cat. no. PHE 207. Canberra: AIHW.
- <sup>ii</sup> <http://www.justreinvest.org.au/research/red-cross-rethinking-justice-vulnerability-report-2016/>
- <sup>iii</sup> <https://ipa.org.au/wp-content/uploads/2017/08/IPA-Report-Australian-Criminal-Justice-Costs-An-International-Comparison.pdf>
- <sup>iv</sup> Muir, K., Martin, C., Liu, E., Kaleveld, L., Flatau, P., Etuk, L., and Pawson, H. (2018). *Amplify Insights: Housing Affordability & Homelessness*. Centre for Social Impact, UNSW Sydney.
- <sup>v</sup> Troy, L, van den Nouwelant, R, Randolph, B. (2019). *Estimating need and costs of social and affordable housing delivery*, City Futures Research Centre, UNSW Built Environment, UNSW Sydney.
- <sup>vi</sup> Taylor, P., Moore, P., Pezzullo, L., Tucci, J., Goddard, C. and De Bortoli, L. (2008). *The Cost of Child Abuse in Australia*, Australian Childhood Foundation and Child Abuse Prevention Research Australia: Melbourne.
- <sup>vii</sup> See: [The Economic Cost of the Social Impact of Natural Disasters – Report Fact Sheet March 2016](#)
- <sup>viii</sup> See: [IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings](#)
- <sup>ix</sup> For example, studies in Victoria estimated that in a cohort of people seeking asylum over 50% met diagnostic criteria for major depressive disorders and post-traumatic stress disorder. [D Hocking, G Kennedy and S Sundaram. *Mental disorders in asylum seekers; the role of the refugee determination process and employment*, Journal of Nervous Mental Disorders) 203 (2015): 28-32]
- <sup>x</sup> Australian Red Cross (2017) *Falling Through the Gap Report – The experiences of people living in Australia on uncertain visa pathways*.
- <sup>xi</sup> Refugee Adjustment Study (2018) *Brief Progress Report: June 2018*. Page 5
- <sup>xii</sup> Ibid.
- <sup>xiii</sup> See: <https://www.homeaffairs.gov.au/research-and-statistics/statistics/visa-statistics/live/immigration-detention>
- <sup>xiv</sup> For example: A comparative Canadian study showed 32% of detained asylum seekers had posttraumatic stress symptoms after 31 days in immigration detention, as compared to 18% of non-detained asylum seekers, and depression levels were 50% higher. [Cleveland, J. (2013). *Psychological harm and the case for alternatives*. *Forced Migration Review*, 44 (7-8).]
- <sup>xv</sup> For example:
- An Australian study demonstrated that longer time in detention was linked to higher reports of depression, with half the population reporting post traumatic trauma symptoms, and a third needing clinical referral for mental health concerns [Young, P., & Gordon, M. S. (2016). Mental health screening in immigration detention: A fresh look at Australia government data. *Australasian Psychiatry*, 24 (1), 19-22.]
  - A review of 10 studies across the world found that anxiety, depression and post-traumatic stress disorder are common, and severity increases with time spent in detention. The negative impacts of detention extend beyond the time of release [Robjant, K., Hassan, R., & Katona, C. (2009). Mental health implications of detaining asylum seekers: Systematic review. *The British Journal of Psychiatry*, 194(4), 306-312]
- <sup>xvi</sup> Refugee Council of Australia (2019) *Offshore Detention Statistics*. Available at: <https://www.refugeecouncil.org.au/operation-sovereign-borders-offshore-detention-statistics/6/>
- <sup>xvii</sup> <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-workforce/psychologist-workforce>