

Productivity Commission inquiry into Mental Health

Submission to Draft Report



January 2020

About NCOSS

The NSW Council of Social Service (NCOSS) works with and for people experiencing poverty and disadvantage to see positive change in our communities.

When rates of poverty and inequality are low, everyone in NSW benefits. With 80 years of knowledge and experience informing our vision, NCOSS is uniquely placed to bring together civil society to work with government and business to ensure communities in NSW are strong for everyone.

As the peak body for health and community services in NSW we support the sector to deliver innovative services that grow and develop as needs and circumstances evolve.

Published January 2020.

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Introduction

NCOSS welcomes the Productivity Commission inquiry into Mental Health Draft Report. The Draft Report provides a comprehensive account of the issues raised during the Inquiry and proposes important reforms to improve mental health for all Australians.

The NCOSS submission to the Issues Paper primarily responded to the below Term of Reference:

Examine how the sectors beyond health, including education, employment, social services, housing and justice, can contribute to improving mental health and economic participation and productivity.

The submission raised a number of issues concerned with the relationship between mental health and poverty and disadvantage and the importance of supports within the community to ensure people can access the right help at the right time. It was pleasing to see the Draft Report provide strong draft recommendations on improving mental health support in education and housing and the recognition of services beyond the health sector.

NCOSS supports the draft findings and recommendations in the Draft Report. NCOSS also supports the key principles that the mental health system should be people-oriented, prioritise prevention and early intervention, and be adequately funded.¹

Consistent with these key principles, NCOSS believes the draft recommendations should be built upon in the Final Report by recognising the importance of adequately funded ancillary services outside the mental health system that keep people supported and connected in their communities, such as generalist support and community transport.

The effectiveness of many of the draft recommendations is also incumbent on the operating and funding environment of the health and community services sector, which affects the services' ability and resources to implement the recommendations.

This second submission to this Inquiry in response to the Draft Report reiterates some of the issues raised in our first submission and during the public hearing held on 25 November 2019. It also includes two case studies provided to us by people with lived experience and service providers that highlight the need to coordinate care for people with complex mental health needs who are seeking or living in social housing.

Summary of recommendations

The following should be included in the Final Report:

1. Expand investment in 'soft entry points' and supports for social inclusion in the community offered by generalist support services.
2. Extend standard contract lengths for mental health and community sector grants to seven years for most contracts and ten years for service delivery in remote Aboriginal and Torres Strait Islander communities.

3. Expand investment in community transport programs and deliver funds more flexibly and directly to communities.
4. Fund community-led, evidence-based programs that support young people to get their driver licence, particularly in regional and remote areas.
5. Resource agencies responsible for social housing to directly provide, or contract in, support and care coordination for people's complex mental health needs.

General comments

The links between poverty, low income, unemployment and mental illness are particularly relevant at a time when the adequacy of income support payments is being examined. The public hearings for the 2019 Senate inquiry into the adequacy of Newstart and related payments demonstrate that people are not getting the right support to get back on their feet, and that the welfare system only further entrenches disadvantage.²

The 2007 National Survey of Mental Health and Wellbeing found that people on income support experience significantly higher rates of mental illness than the broader population.³ While accepting that the adequacy of income support is beyond the scope of this Inquiry,⁴ NCOSS was pleased to see the Draft Report include the voices of people with lived experience who provided accounts of the negative impact of inadequate income support on their wellbeing.⁵

NCOSS urges the Commission to consider in its Final Report how the current income support system acts as a barrier to people accessing care and opportunities, and how this impacts their mental health and wellbeing. This should include considering more deeply the impact of how the income support system is administered and enforced. While Draft Recommendation 14.4 seeks to build more flexibility and support into mutual obligation requirements for income support recipients with complex needs, NCOSS suggests this could be strengthened by discouraging any punitive approaches to income support compliance or imposing onerous conditions on already vulnerable groups.

Supporting wellbeing and connection in the community

NCOSS supports the draft finding (20.1) that social exclusion is associated with poor mental health⁶ and hopes to see the Final Report include more robust recommendations to improve social inclusion. Governments at all levels should be investing in services that help keep people well in the community for longer, particularly through access to non-stigmatising, soft entry points to mental health support, and generalist support for wellbeing and social connection.

Generalist, place-based support services like neighbourhood centres (also known as 'community centres' or 'neighbourhood houses') financial counselling and family services play an important role in supporting mental health through social participation and inclusion. While not considered as part of the mental health system, these services support prevention through social participation to keep people well in the

community for longer. In many cases, they will also help people who have had an episode in acute mental health care and need support to stay connected in the community. Across Australia, almost 8 in 10 (79%) clients of neighbourhood centres are identified as otherwise being at risk of social isolation.⁷ Given the strong link between poverty and poor mental health, it is also important to note that the proportion of clients identified as being on low incomes is even higher at 84%.⁸

The reach of these local support services is unique and spans across metropolitan, regional and remote areas, with at least one centre located in most federal electorates.⁹ This familiarity with and grounding in local community enables them to provide services in a non-threatening environment and serve as soft entry points for people who would otherwise fall through the gaps.

Services like neighbourhood centres provide a range of activities and supports for people who may not have a diagnosed mental health condition but are at risk of social isolation and other determinants of poor mental health. The vast majority offer programs and support groups to assist with health and wellbeing, community development, personal development, family support, employment support and financial counselling, as well as information on and referral to more intensive services such as housing. They also play key roles in supporting local communities with disaster and emergency relief, during periods known to have a significant impact on mental health within the community.¹⁰

Local support services must be adequately funded to recognise their role in keeping people well in the community for longer, and to continue their important work in making communities stronger, more resilient and connected.

1. Expand investment in 'soft entry points' and supports for social inclusion in the community offered by generalist support services.

Enabling services to better support the community

In the Draft Report and a 2017 inquiry into human services reform,¹¹ the Commission acknowledged the impact of short term funding arrangements on the sector's ability to build sustainability, trust and stability in services. The Final Report should recommend that minimum contract lengths be increased across the health and community services sector, more broadly than what is currently recommended in the Draft Report for consumer and carer peak bodies and psychosocial support services.¹²

Shorter funding cycles undermine service sustainability, particularly in regional and remote communities, where it is harder to attract and retain skilled staff with no security of tenure. It can also be challenging to build the awareness and trust in the community needed for programs to start engaging clients and demonstrating outcomes before the contract is up.

The health and community services sector, including those working both directly and indirectly in mental health, now operates in an increasingly complex environment impacted by the rollout of the NDIS, competition, commissioning and contestability, and the interaction between state and federal funding. This

continues to put significant pressure on the sector's capacity to respond to the growing and diverse needs of the broader community, let alone remain sustainable.

Services are increasingly under pressure and concerned about how to best support their clients in such a changing landscape. They are losing funding in competitive re-tendering processes and are worried about ongoing viability. Many are taking steps such as closing services, reducing staff hours, and relying on more part time and casual staff.¹³

If services are to respond effectively to the ongoing and diverse needs of their local communities, particularly in regional and remote areas, governments need to remove funding uncertainty and allow time for better planning, implementation and outcomes measurement.

A clear first step is extending standard contract lengths in line with recommendations from the Commission on human services reform,¹⁴ and from the recent Senate inquiry into the accessibility and quality of mental health services in regional and remote Australia.¹⁵

2. Extend standard contract lengths for mental health and community sector grants to seven years for most contracts and ten years for service delivery in remote Aboriginal and Torres Strait Islander communities.

Increasing access to services through transport options

Improved transport options need to be considered in the Final Report as a key measure for better service access in regional and remote communities.

The Draft Report briefly discusses geographical barriers to accessing services, and the link between social exclusion and a lack of transport, particularly in regional and rural areas. For mental health consumers, a lack of transport is both a major barrier to accessing mental health services and in itself a contributing factor affecting mental health.¹⁶ In addition, the cost of travel can be a significant barrier to accessing timely health care, particularly for people who must either travel frequently or travel long distances.

Evidence provided to the 2018 Senate inquiry into the accessibility and quality of mental health services in regional and remote Australia found that service providers in these areas need flexibility within their funding models to provide transport services and solutions to overcome lack of transport.¹⁷ In NSW there are not enough meaningful or accessible public transport options in rural and remote areas. Viability is a significant issue for transport providers, given the long distances and scattered populations.¹⁸ This has resulted in pressure on community transport providers, who are not adequately resourced to respond to demand in a way that reflects the specific and unique needs of their local community.¹⁹

Transport as a barrier to services and opportunities has also been identified as a particular challenge for socially excluded children and young people in rural and regional areas, who struggle to meet the costs and requirements to get a driver licence.²⁰ In an environment where 61% of young people aged under 25 lack a

driver licence and up to a quarter cite transport issues as a key barrier to getting a job,²¹ the importance of empowering young people to get their licence cannot be ignored.

More young people need to be able to drive to not only access services but also opportunities that will contribute to their social participation, independence and overall mental wellbeing. Driving Change (case study provided in the NCOSS submission to the Issues Paper) is an example of an effective, community-led program aiming to increase licensing rates among young Aboriginal people and people experiencing disadvantage aged 16-24 years in regional areas.

The Draft Report also recommends that supported online treatment options should be integrated and expanded to improve access to services.²² NCOSS supports that online and e-health services have the potential to improve access to mental health services for people in regional and rural areas. However, telecommunications and internet connectivity remains an issue in many regional and remote areas, rendering e-health services unavailable for many of these communities. In addition, while online and digital solutions certainly have a place in promoting and servicing mental health, they do not replace the need for people to be supported to access face-to-face services.²³

3. Expand investment in community transport programs and deliver funds more flexibly and directly to communities.
4. Fund community-led, evidence-based programs that support young people to get their driver licence, particularly in regional and remote areas.

Supporting social housing tenants with complex mental health needs

There is a clear responsibility for agencies administering for social housing to look after more than just housing needs and NCOSS supports the draft recommendation (15.1) that housing services should increase their capacity to prevent people with mental illness from experiencing housing issues or losing their home. However, the recommendation should be strengthened in the Final Report to ensure that agencies responsible for social housing are resourced to directly provide, or contract in, support and care coordination for people's complex mental health needs.

Poor mental health is closely linked with the experience and risk of homelessness. The rate of mental illness among Specialist Homelessness Services clients is significantly higher than the general population (31% in 2015-16 compared to 16.2%), while in NSW, the number of people seeking specialist accommodation support with mental health issues has increased by an average of 14.8% per year since 2012.²⁴

Further, data analysis from the Brotherhood of St Laurence shows social housing tenants experience social exclusion at more than twice the rate of people living elsewhere.²⁵

The following case studies were prepared for the public hearing on 25 November 2019. As there was insufficient time at the hearing for these to be presented they are included here in full for the Commission's consideration.

Case study: 'John'

John* is an Aboriginal man in his late 40s who was the victim of a home invasion while living in social housing in regional NSW. John was physically attacked and left in a medically-induced coma due to severe head trauma. Due to the attack, John continues to experience post-traumatic stress disorder, night sweats, severe headaches and seizures, all of which have exacerbated pre-existing mental health conditions.

John's injuries made him eligible for the Disability Support Pension and he travelled to Sydney a couple of years ago initially to appear at the trial of his attackers. This trial ended up lasting 14 months, during which John was expected to stay in Sydney and limit his activities outside of his allocated accommodation. John was not provided with health or medical support during this time. The trauma and stress from his attack, injuries and the ongoing trial led John to substance use as a coping mechanism.

John has since permanently relocated to Sydney and has been seeking stable social housing for some time. He has been experiencing significant challenges due to an ongoing dispute with a neighbour, who took out an Apprehended Violence Order against him. When trying to access his own property, his neighbour called the police who charged John with breaching his AVO and took him into custody for 5 months.

During his time in custody, John's social housing was relinquished on his behalf without his knowledge or consent. After he was released, the police told him to return to his place of residence but John came home to find his house boarded up and belongings thrown away due to his absence. When John tried to gain access to his home again, the police were called and found him to have breached his Intensive Correction Order. John was taken back into custody for a further 8 months.

Upon release from custody, John's house was no longer available to him and he had to seek emergency housing. This causes significant problems in satisfying his probation requirements as he does not have a fixed address. At no point during both periods of release was he given any care coordination or aftercare from government agencies to support his transition back into the community and help him find stable housing.

John had previously applied for a NDIS plan and qualified, but was not informed that access to a plan had been granted. Consequently, after 12 months his NDIS plan expired while he was in custody. He is now trying to reapply for a plan but has to start from scratch rather than reactivate his original application. He now faces significant challenges in being granted access to his own paperwork from previous services he used, in order to start a new application.

John is determined and resilient under the circumstances but his mental health continues to suffer under so much stress, and he often experiences 'black dog' days. He says there are not enough culturally appropriate, Aboriginal community controlled services or safe spaces for people in the community to connect and learn about the mental health supports available. He says none of the parts of the system talk to each other, the system works against people, is too complicated and should be simplified.

Case study: 'Jane'

Platform Youth Services first met Jane* in October 2018 at the time she was homeless within the NSW Hospital system. Jane had been in the Hospital system for approximately 6 months and at the onset of this stay she had become dependent on a wheel chair due to a range of complex medical issues. She was also dealing with PTSD, high anxiety and depression having being diagnosed with these issues prior to her hospital admission. Jane had limited contact and support from her family, due to a history of physical and psychological abuse.

On first meeting with this client it was clear to staff that despite the struggles she was facing she had a tremendous amount of resilience. It was also clear that Jane was too high needs for our service, however she also met the gaps in all other services who were then unable to work with her. Her case worker advocated strongly for her to be taken on as client and it was agreed that strategies needed to be put in place as well as time lines for this support due to her needs being out of our target group.

When we first engaged with Jane her immediate physical health needs had been met although there appeared to be some confusion around her mental health and any diagnosis being given. The Hospital were at a loss on a release plan due to the property she had been formerly living in, and was still paying rent on, was a private boarding house and in no way wheel chair accessible. There were discussions at the time by Hospital staff about exiting Jane into the temporary accommodation system/homelessness. These decisions were being made with no regard on how they were impacting and would continue to impact her mental health. Platforms case manager strongly advocated that they give the service time to find a stable housing situation for Jane instead of exiting such a vulnerable client into homelessness.

These supports included gaining advice from Tenants' Advice and Advocacy Services on how Jane could exit the lease she had with the boarding house (she had previously emailed the landlady to explain her situation but the landlady had refused to let her out of her lease). Unfortunately it became quickly clear that the landlady was well known to them due to her unscrupulous practises. Jane was offered support to take the land lady to tribunal however due to her limited mental health capacity at the time she decided to forfeit her bond and advanced rent. Again no agencies or services were able to take into consideration the impact that their decisions would have on a vulnerable young person with mental health concerns. As a result Jane's mental health and self-worth were on a decline.

Jane had previously applied for NDIS support but due to being unable to prove "permanence" of her disability her first application had been denied. The Hospital staff started work to re submit her application with additional information and focusing on her mental health but this process was stopped by the director of the hospital due to the length of time this would take. Without an NDIS Package Jane was not eligible to access disability support service/specialist disability housing or any mental health supports. Jane could also not access mental health housing due to the lack of properties and long waiting lists. Any support she was able to access was paid for privately either by herself or with support from our service which is limited due to us being a not for profit service.

Jane's case worker helped her to complete an application for Priority housing through the NSW Department of Communities and Justice (DCJ) and advocated strongly on her behalf to have her application expedited. DCJ quickly approved Jane's request for Priority housing, but due to the lack of available wheelchair accessible houses she was placed on the waiting list. Thankfully DCJ were one of the few services that were able to take mental health into consideration when making decisions and they also approved her for the private rental subsidy. We then completed the living skills program Rent it keep it with Jane and started to look for properties.

However finding a suitable property that met her specific needs was stressful and taking a lot longer than anticipated. This process was having an increased negative impact on Jane's mental health and the Hospital had yet again started talking about exiting her into temporary accommodation.

Discussions were had with our partners at Wentworth community housing and it was decided that although Jane's housing requirement was greater than our norm we would accommodate her in one of our Transitional Housing properties through Wentworth Community Housing. In early January 2019 Jane moved into a temporarily modified transitional property.

This then gave Jane the space and time to organise service to support her living independently within the community. With support her mental health rapidly improved after leaving the health system.

We were still unable to access any mental health supports for Jane as the medical team believed her symptoms to be psychosomatic and the mental health team stating all issues were medical, she was continuing to fall between the gaps. The only services that were able to assist were the Hospital physiotherapy team who put ramps and hand holds in place and Ability Links who were working with Jane to reapply for NDIS support.

We then worked with the Department of Communities and Justice Housing to secure long term housing for her using the private rental subsidy. In June this year she moved into her own property with support from community programs she is becoming increasingly more independent with every day and Platform could not be prouder of how far she has come in such a short time.

**Real names withheld.*

Resourcing social housing agencies to provide for mental health care coordination would help to ensure tenants with complex mental health needs don't enter crisis and are supported to maintain stable housing.

6. Resource agencies responsible for social housing to directly provide, or contract in, support and care coordination for people's complex mental health needs.

We would welcome the opportunity to discuss the issues raised in this submission. For further information please do not hesitate to contact Director of Policy & Research Anna Bacik

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