



THE SOCIAL AND ECONOMIC BENEFITS OF IMPROVING MENTAL HEALTH

Anglicare Victoria submission to the
Productivity Commission

1 April 2019

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Introduction

Anglicare Victoria works to transform the futures of children and young people, families and adults. We offer a comprehensive network of high quality services that aim to significantly improve in the lives of the young people, children and families/carers with whom we work. As Victoria's leading child and family welfare organisation, we are single-minded in our mission to create positive change for the most vulnerable and disadvantaged members of our community.

In any given year we will provide residential, foster or kinship care for over a thousand Victorian children, help over 120 families to stay together through our Rapid Response and Cradle to Kinder Programs and support over 3000 parents through the evidence-based ParentZone program that helps people build better parenting skills. We empower families to build better futures through financial counselling and improve educational outcomes for young people in out of home care through the TEACHaR program, which has delivered measurable improvements in educational engagement and attainment at over 165 locations across the state. Anglicare Victoria is also a major provider of Men's Behaviour Change and other family violence services across the state.

Supported by a dedicated team of 1500 staff and 2000 volunteers statewide, we are committed to a transformational agenda that aims to improve outcomes for our children, young people and families by committing to continuous improvement, rigorously monitoring our own outcomes and performance, and seeking new and innovative ways to deliver care. Examples include establishing the first ever Parentzone hub co-located with a local school, and working with government to develop one of Victoria's State's first social impact bonds, COMPASS. It aims to improve outcomes for young people leaving care. Building on our proven track record, we have grown at about 20% per annum over the last five years, consolidating our position as one of Victoria's leading providers in our field.

At Anglicare Victoria, we believe that every child and young person has the right to fulfil their potential and shine. For any child or young person removed from their family home, Anglicare Victoria carers and staff provide home-based care, keeping children safe and protected in a loving environment, working every day to meet their immediate needs and providing long term support and care as they grow. We also deliver a suite of programs with a strong emphasis on building skills and providing opportunity, to help young people overcome barriers and achieve, including a range of expert supports to help families stay together and to build safe and happy home environments.

Anglicare Victoria believes that better supporting the mental health of the children, families and young people will continue to be an important reform direction for child and family services, including child protection, and that there is significant opportunity for the specialist mental health system, as well as broader health and social care approaches, to improve outcomes in this area. This submission recommends

- a stronger focus, targeted focus on the mental health needs of children and families who have had contact with the child protection system, including but not limited to those in out-of-home care
- provision of mental health support and services, including preventative activities that build resilience, early intervention and more accessible specialist services for this very high risk target group

- better support and use of data, evaluation and research to inform effective responses, and
- better recognition of the potential role non-government, non-health social care services as an accessible and appropriate access point for people who may benefit from prevention and early intervention activities, as well as a referral source for hard-to-reach populations

1 Assessment approach

What suggestions, if any, do you have on the Commission’s proposed assessment approach for the inquiry? Please provide any data or other evidence that could be used to inform the assessment.

Anglicare Victoria strongly urges the Inquiry to address the mental health needs of children and families who have had contact with the child protection system, including but not limited to those in out-of-home care as part of its investigations, including consideration of the adequacy of current services responses for this cohort.

Prevalence

As a group, young people leaving care have low levels of educational attainment, and high rates of unemployment, mobility, homelessness, financial difficulty, loneliness and physical and health problems. There is also a significant body of evidence, both local and international, demonstrating that a substantial proportion experience mental health issues.¹ There is meta-analytic evidence indicating that the prevalence of disruptive disorders in Out of Home Care (OoHC) populations is 20-34%².

Further evidence is summarised in the 2014 paper by Baidawi et al³, and includes

- A 2006 survey of young people in residential care in Victoria that found that 65% had results indicating an abnormal risk of a diagnosable mental health disorder
- A South Australian study that found the prevalence of mental health issues among children and young people in foster care was two to five times higher than the general population
- A New South Wales study that found that children in foster and kinship care had ‘poor mental health and social competence relative to normative and in-care samples.

As the paper notes, residential care and institutional settings often excluded in research, so these issues may be under-reported.

Further, there is evidence that poor mental health outcomes for this group extend into adulthood, with studies in both Australia and the UK indicating mental health issues for between 30 and 45 percent of care leavers⁴. An estimated 16% of care leavers are Alcohol and/or Other Drug dependent⁵.

¹ Baidawi, S., Mendes, P., & Snow, P. (2014). Young People in, and Transitioning from, Out-of-home Care and their Mental Health Issues: A Call for Evidence. *Children Australia*, 39(4), 200-205. doi:10.1017/cha.2014.27

² Bronsard, G., Alessandrini, M., Fond, G., Loundou, A., Auquier, P., Tordjman, S., and Boyer, L (2016) The Prevalance of Mental Disorders Amond Children and Adolescents in the Child Welfare System” A systematic Review and Meta-Analysis *Medicine* 95(7):e2622

³ ibid

⁴ ibid

⁵ Courtney et al (2007), Midwest evaluation of adult functioning of former foster youth from Illinois: outcomes at 19.

The process of leaving care can impact on mental health, with Baidawi et al noting that “such a non-normative, compressed and accelerated transition during a highly significant developmental period will both be impacted by, and may exacerbate, pre-existing mental, emotional and behavioural problems”. The authors go on to note that poorly planned transitions can be re-traumatising, “representing a final experience of rejection and abandonment”⁶.

Young people in care have often experienced significant trauma before coming into care. Further, there is evidence showing that experiences in care (e.g. instability in placements, trauma and conflict in care settings) can adversely impact on mental health and other outcomes.

Similarly, there are a number of features of the justice system that do not support the mental health and development of young people, and in fact may be actively damaging by creating additional trauma or reinforcing existing trauma. For example, in Victoria it is possible under current legislation for a child to be held in solitary confinement, and for DNA to be taken from a child without that child’s consent. Other forms of restraint, including hand cuffs, are sometimes used on children under eighteen. Similarly, under current legislation, it is possible for a young adult to be given a mandatory custodial sentence for certain offences, including harming an emergency services worker.

Tragically, evidence suggests that having been in OOHHC care is also associated with increased risk of suicide and suicidal ideation. A systematic review of studies indicating the prevalence of suicidal ideation of young people in care was 24.7% compared to a rate of 11.4% young people in the general population, and that the prevalence of suicide attempts also showed a significant disparity (3.6% compared to 0.8%).⁷

- A review of Scandinavian studies indicates significantly higher likelihood of early mortality by suicide for people who grew up in care⁸
- A Swedish study found that mothers who had been in care themselves were 2.47 times more likely to die by suicide than mothers who had not been exposed to OoHC. The same study also found that mothers with two generations of exposure to OoHC (themselves and their children) were 5.52 times more likely to die by suicide than mothers who had not been in care, and 2.35 times more likely to die by suicide than mothers who themselves had been in care but whose children had not been placed in care⁹.
- A cross sectional survey of the correlates of suicidal ideation and suicide attempts among prisoners in NSW found that having lived in OoHC as a child (before the age of 16) is correlated with rates of lifetime suicidal ideation 1.78 times higher (margin of error 1.33-2.39 times higher) for this cohort. The same study also found that prisoners who had lived in

⁶ Baidawi et al (2014) op cit

⁷ Evans, R, White, J., Slater, T., Morgan, H., Strange, H., and Scourfield., J. (2017) Comparison of suicidal ideation, suicide attempt and suicide in children and young people in care and non-care populations: systematic review and meta-analysis of prevalence. *Children and Youth Services Review*, Volume 82, pp. 122-129.

⁸ Kääriälä, A. and Hiilamo, H., Children in out-of-home care as young adults” A systematic review of outcomes in the Nordic countries (2017) *Children and Youth Services Review* 79. Available at https://www.researchgate.net/publication/317282805_Children_in_out-of-home_care_as_young_adults_A_systematic_review_of_outcomes_in_the_Nordic_countries

⁹ Wall-Weiler, E., Bolton, B., Liu, C., Wilcox H, Ross LL., and Hjern, A (2018) Intergenerational involvement in out-of-home care and death by suicide in Sweden: A population-based cohort study. *Journal of Affective Disorders* Volume 230, pp 506-512. Available at <https://www.sciencedirect.com/science/article/pii/S0165032718305494>

OoHC as a child were 2.2 times more likely to have engaged in a suicide attempt in their lifetime (margin of error 1.29-3.74 times higher)¹⁰

It is AV's view that, in addition to a specific focus on prevalence and outcomes for young people with experience of care, this Inquiry should also consider whether systemic improvement in models of care within the child protection and youth justice systems could improve young people's mental health, and promote resilience and recovery. Interventions specifically targeting mental health within these settings will not achieve the desired outcomes unless supported by health promoting service-models.

It is also important to note that specifically tailored and targeted services treatment responses will be needed if we are to cater adequately to the mental health needs of this target group. As noted by the Royal Australian and New Zealand College of Psychiatrists:

Children in OoHC often present with complex psychopathology related to prior experiences with carers, exposure to perinatal risk (e.g. maternal drug use during pregnancy) insecure, disorganised and disrupted attachment relationships, and the cumulative effects of childhood maltreatment including traumatic exposure. Australian and international studies show a high prevalence of emotional and behavioural disorders in the fostered population. Developmental delays are also common, including speech and language cognitive development and gross and fine motor skills problems (Chambers et al 2010; Nathanson & Tzioumi 2007; Stock & Fisher 2006; Tarren-Sweeney & Hazell 2006; Tarren-Sweeney 2008). These can confound both the child's capacity for communication and the carer's expectations about and responses to the child. These factors add to the complexity of assessment and intervention.¹¹

Economic impact

There is significant evidence that the poor outcomes for these children and young people has significant economic impact, meaning that comprehensive and broad-scale implementation of effective, evidence based interventions, are likely to be at worst, cost-neutral, and at best deliver significant economic benefit.

Anglicare Victoria commissioned Deloitte Access Economics to conduct a report, 'Raising our children: guiding young Victorians in care into adulthood,' (2016). This report provides a cost and benefit analysis focusing on the cost of young people leaving care and how this cost imposes a financial burden on state and territory and federal Governments. By extending the age of state care to young people to 21 years, not only would this give them a chance at a successful future, it also makes economic sense, saving the Government money and lessening the social welfare burden long-term.

As part of the report, a complete Australian State and Territory comparison was conducted. The findings show that for every dollar spent on extending support to age 21, the community would save between \$1.40 and \$2.69, depending on the State.

¹⁰ Larney, S., Topp, L., Indig, D., O'Driscoll, C., and Greenberg D (2012) A cross-sectional survey of prevalence and correlates of suicidal ideation and suicide attempts among prisoners in New South Wales, Australia, *BMC Public Health* 12:14. Available at <https://bmcpublihealth.biomedcentral.com/articles/10.1186/1471-2458-12-14>

¹¹ Royal Australian and New Zealand College of Psychiatrists (2015) The mental health care needs of children in out-of-home care. Position statement 59. Available at: <https://www.ranzcp.org/news-policy/policy-submissions-reports/document-library/the-mental-health-care-needs-of-children-in-out-of>

The Victorian saving would be \$1.84 and the NSW saving would be \$2.57. The annual cost of continuing foster care or kinship care in Victoria would be \$25,000 per person annually, according to the study, however the benefits would be \$37000.

Although there are costs associated with extending care, the benefits would outweigh these costs. For example, the Deloitte report notes that running an OOHC program in the Northern Territory was the most expensive in Australia at \$52,351.66 however this was offset by large savings in reduced housing support as a benefit of extending care.

Benefits such as improved access to education, employment, improved housing stability, reduced interaction with the justice system, improved access to healthcare and reduced incidence of alcohol and/or drug dependence for young people leaving care will deliver these economic benefits.

It should be noted, however, that the potential economic gain would be even greater if the child and family welfare system was better oriented to prevent family breakdown and dysfunction, and thereby minimise the need for young people to enter into out-of-home care. Programs such as AV's *Rapid Response* demonstrate that timely evidence-based interventions can make families safer and prevent the need for removal of children from the home¹².

2 Structural weaknesses in healthcare

What have past reform efforts by governments over many years had limited effectiveness in removing the structural weaknesses in healthcare for people with a mental illness? How would you overcome the barriers which governments have faced in implementing effective reforms?

Discontinuity between disability, primary care and acute mental health services continues to be a significant structural weakness in the healthcare system, and many people – including many people at high risk of poor mental health outcomes – continue to “fall through the cracks”. This problem appears to be particularly pressing in relation to the provision of effective prevention and early intervention activities, where services can be difficult to identify and access¹³.

These problems often becomes particularly evident during discharge and discharge planning. For example, there have been cases where a young person who is being supported to maintain stable housing in our Lead Tenant program has experience with mental illness, including periods as an inpatient in a mental health service. Greater engagement in discharge planning would enable our staff to better support that young person when they return home, and reduce the risk of further illness and re-admission. Staff report receiving little information about issues such as risks and triggers, medication and medication safety, and how to identify and respond appropriately to symptoms reoccurring. While generic training can address this in part, it will not address the circumstances of particular clients.

Anecdotally, other carers – including family members – have reported a similar lack of involvement in planning, and lack of acknowledgement that they are an important resource and source of information

¹² For further information on Rapid Response, see here: <https://www.anglicarevic.org.au/news/anglicares-rapid-response-keeps-kids-safe-home/>

¹³ Australian Government (2015) *The Mental Health of Children and Adolescents: Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing*.

in the formulation of an effective care plan. Clearer recognition of the role of both consumers and carers (including other service providers) in the care team is a structural weakness that could be addressed by changes in practice.

What, if any, structural weaknesses in healthcare are not being targeted by the most recent and foreshadowed reforms by governments? How should they be addressed and what would be the improvements in population mental health, participation and productivity?

The Australian Government's survey-based report *The Mental Health of Children and Adolescents* highlights the importance of non-health settings and providers as a source of help. However, there remains a lack of robust pathways for children, young people and their families that support access to mental health support, particularly in relation to early intervention and episodic care. Similarly, as noted above, discharge pathways out of specialist services rarely link well with non- health services

Further reform is needed to build and support these linkages, so that the strengths of organisations like Anglicare Victoria that work with vulnerable and at risk populations and their families are better utilised to support and maintain good mental health, and provide better access to more specialist care. This network should also include schools, the community (including parents, carers and peers) and utilising alternative platforms such as the internet to provide services, to supplement traditional health-based models of care delivery.

(see also comments on workforce issues).

3 Specific health concerns

Should there be any changes to mental illness prevention and early intervention by healthcare providers? If so, what changes do you propose and to what extent would this reduce the prevalence and/or severity of mental illness? What is the supporting evidence and what would be some of the other benefits and costs?

As noted by the Australian and New Zealand College of Psychiatrists, "children in OoHC warrant special attention and priority access to comprehensive health and developmental assessments and multi-disciplinary mental health care that can address their complex health, psychosocial and developmental needs within the context of their placement and the care system.¹⁴"

AV advocates a person-centred approach to mental health services that is flexible, and acknowledges that people's needs in relation to mental health care change significantly over time. Extensive eligibility requirements are used to "gatekeep" and appear to be primarily driven by a desire to limit access to services, rather than promote it. This is antithetical to prevention and early intervention, and particularly obstructive for hard-to reach populations (such as young people experiencing significant trauma and disruption) who may not have the skills nor the motivation to negotiate these barriers. It is important therefore that the health system make more use of outreach models and service models that locate

¹⁴ Royal Australian and New Zealand College of Psychiatrists (2015) The mental health care needs of children in out-of-home care. Position statement 59. Available at: <https://www.ranzcp.org/news-policy/policy-submissions-reports/document-library/the-mental-health-care-needs-of-children-in-out-of>

mental health expertise within other services, rather than relying on clients to come to approach health services for help.

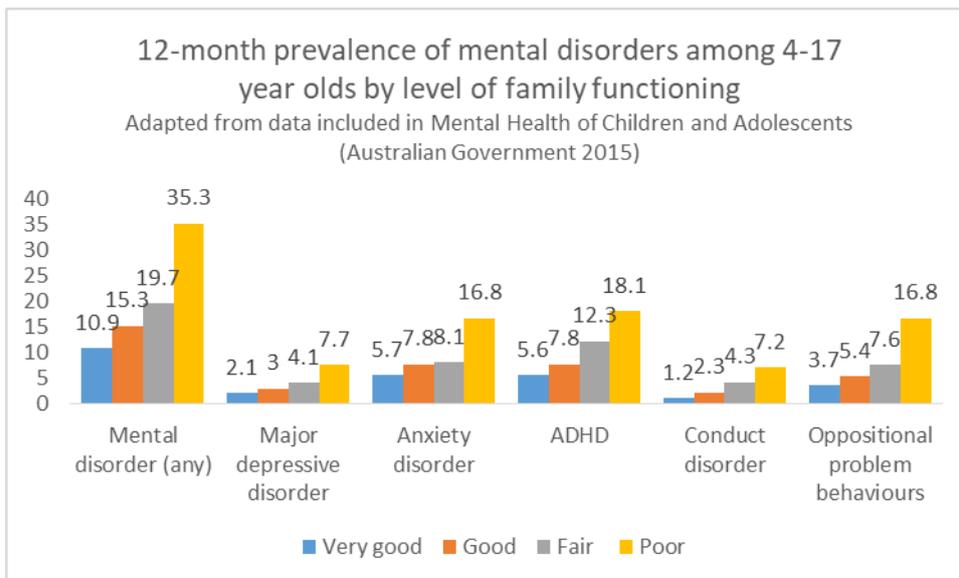
It is also important that prevention and early intervention approaches recognise that mental health issues affect whole families, and that strong relationships and connection are protective factors that increase resilience. Data from *The Mental Health of Children and Adolescents*¹⁵ report demonstrates the strong correlation between family functioning and poor mental health (see Figure 1).

Although the results do not establish causal relationships, these results do at least suggest that a strengthened focus on families could assist in improving mental health outcomes, and/or reduce the impact of poor mental health may have on the functioning of the family unit and relationships. Health systems and health professionals that maintain a traditional focus on one-on-one client/clinical relationships, can struggle to work effectively within the context of a family dynamic. This is particularly concerning where mental health and/or drug and alcohol issues coexist with financial hardship, violent behaviour in the home, or lack of parenting skills and effective child care.

Which forms of mental health promotion are effective in improving population mental health in either the short or longer term? What evidence supports this?

Figure 1

No comment



¹⁵ Australian Government (2015) *The Mental Health of Children and Adolescents: Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing*.

What changes do you recommend to healthcare to address the specific issues of suicides and comorbidities among people with a mental illness? What evidence is there to support your suggested actions and what types of improvements would you expect in terms of mental health, participation and productivity?

Refer comments elsewhere in this submission about the role of non-health services in mental health and prevention and early intervention, and in building resilience.

What overseas practices for supporting mental health and reducing suicide and comorbidities should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?

No comment

4 Health workforce and informal carers

Do the configuration and capabilities of the professional health workforce need to change to improve where and how care is delivered? If so, how should the workforce differ from current arrangements? How would this improve population mental health, participation and productivity?

Effective and timely interventions for high-risk groups continues to be a challenge, and needs to be greater capacity amongst mental health practitioners to work with families as a whole in order to create sustainable, self-directed solutions to mental health management and maintenance..

One possible solution to this problem is to resource community service organisations (CSOs) to directly employ staff with specialist mental health expertise, as part of a multi-disciplinary care team within CSOs, rather than rely on referral and secondary consultation to provide this support to our clients, building on models such as Multisystemic Therapy (MST)¹⁶.

Multisystemic Therapy® (MST®) is an intensive family- and community-based treatment that addresses the multiple causes of serious antisocial behaviour in juvenile offenders. The MST program seeks to improve the real-world functioning of youth by changing their natural settings - home, school, and neighbourhood - in ways that promote prosocial behaviour while decreasing antisocial behaviour. MST teams consist of An MST Team of a supervisor and 4 therapists each serves an average of 5 families at a time. Supervisors must be licensed Masters mental health professionals. Therapists should be Masters Level, but license is not required¹⁷.

This model has shown positive mental health outcomes include decreased psychiatric symptomatology, improvements in externalising behaviour and internalizing symptoms, reductions in sexual behaviour problems and decreases in aggression, delinquency, psychopathic traits and oppositional defiant

¹⁷ See here for further information: <https://www.blueprintsprograms.org/program-costs/multisystemic-therapy-mst>

disorder. In the Australian context, however, cost and limited supply of the required qualified workforce represent significant barriers to establishing and sustaining such models.

Our experience suggests there can be a lack of skill and expertise among specialist health care professionals including mental health clinicians in working with children and young people who present with complex and sometimes confrontational behaviours. Because of this, clinical mental health care staff can be hesitant to work directly with highly complex clients in care settings. While this may be understandable from an individual practitioner point of view, it begs the question of who can and should provide clinical mental health services for this very vulnerable group, and what further workforce capacity should be developed to provide for this high-needs group.

What can be done to address health workforce shortages in regional and remote areas? In which areas or circumstances would greater use of technology and tele-health services be suitable? What prevents greater remote provision of services to address the shortages?

No comment

What restrictions exist on the scope of practice for different professions, such as GPs, nurses, clinical versus other psychologists, and social workers? Are these restrictions unwarranted and, if so, how could they be addressed and what would be some of the costs and benefits?

No comment

What could be done to reduce stress and turnover among mental health workers?

No comment

How could training and continuing professional development be improved for health professionals and peer workers caring for people with a mental illness? What can be done to increase its take up?

Given the very high prevalence of poor mental health amongst young people in OoHC, there is a strong argument for both workers and carers in the field of child and family welfare to have strong skills both in working with people whose mental health is poor, and in providing and delivering therapeutic interventions including preventative and early intervention strategies.

It is important to note, however, that prevailing funding arrangements do not always support the employment of staff with formal skills and qualifications in this area. For example, although we know that the outcomes for children and young people in residential care are poor, only some residential facilities in Victoria are funded at the higher "Therapeutic Residential Care" rate. Given the complexity of behaviours in these services, AV believes that resourcing providers to enable therapeutic models to be implemented across residential care setting would deliver significant long terms productivity savings by delivering better outcomes (improved health and mental health, better educational and employment outcomes and reduced justice system involvement) across the life course of people who are placed in OoHC in childhood

What changes should be made to how informal carers are supported (other than financially) to carry out their role? What would be some of the benefits and costs, including in terms of the mental health, participation and productivity of informal carers and the people they care for?

Parents concerned about their children's mental health identify not being sure to get help (39.6%) and not being able to afford help (37%) as key barriers to seeking or receiving help¹⁸. This indicates that there continues to be systemic barriers for people who are seeking to support young people's mental health, and is likely to result in significant missed opportunities for beneficial intervention at an early stage.

AV also supports increased financial and practical support for foster and kinship carers given that they are often tasked with caring for young people with significant experience of trauma and other issues that potentially impact on their mental health.

As noted earlier, clearer recognition of the role of both consumers and carers as an integral part of the care team would deliver better outcomes both for people experiencing poor mental health as well as minimising the extent to which that situation impacted on the participation and productivity of all members in the household in school, work and the community.

Similarly, other services that may be working with that person or that person's family represent a resource that could be providing more effective support if they were more closely engaged with mental health services in planning around the person's needs, particularly in relation to discharge planning after an acute inpatient episode.

5 Housing and homelessness

What approaches can governments at all levels and non-government organisations adopt to improve:

- *support for people experiencing mental illness to prevent and respond to homelessness and accommodation instability?*
- *integration between services for housing, homelessness and mental health?*
- *housing support for people experiencing mental illness who are discharged from institutions, such as hospitals or correctional facilities?*
- *flexibility of social housing to respond to the needs of people experiencing mental illness?*
- *other areas of the housing system to improve mental health outcomes?*

AV believes that the lack of affordable housing options for young people leaving care has a serious and ongoing impact on their mental health, as well as other outcomes.

¹⁸ Australian Government (2015) op. cit.

According to the Australian Bureau of Statistics, more than half of Australia's 18-24 year olds live at home, and the most recent HILDA study (an Australian household based panel study undertaken by the University of Melbourne) found that for 18-21 year olds the figure is even higher at 80%. In contrast, statutory care in Victoria ends when a young person turns 18. It has been estimated that 39% of care leavers become homeless¹⁹. Lack of suitable supported housing options identified by care leavers as key driver of offending in post-care period²⁰.

Anglicare Victoria and VincentCare Victoria came together in 2016 to begin the development of a unique and innovative service model, specifically designed to meet the needs of young people leaving care: the COMPASS Social Impact Bond.

Compass combines housing with dedicated, personalised case management and access to additional specialist supports. The program provides different levels of support and types of housing according to the young person's assessed level of need.

Both specialist services and housing will also draw on the existing service system: Anglicare Victoria's key workers will draw on locally-established relations across the service system to broker referral pathways to local specialist services for young people. VincentCare Victoria will leverage its strong relationships with real estate agents and rental property managers to secure housing for participants, supplemented by purchased properties.

Initially funded through private investment, COMPASS will generate government-financial returns for investors which are derived from cost-savings for government, and are variable based on measured performance against the following 3 outcome measures: housing, health and justice. It is hoped that the additional evaluation commissioned by the State government will provide a more comprehensive view of client outcomes.

Performance will be assessed by comparing the outcomes for COMPASS participants with a statistically matched, stratified control group of care leavers across the state. Results will be independently certified.

What evidence can we draw on to assess the efficiency and effectiveness of approaches to housing and homelessness for those with mental ill-health?

No comment

What overseas practices for improving the housing stability of those with mental illness should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?

Programs that have been demonstrated to improve housing outcomes for care leavers (or similar comparable cohorts) include

- Youth Villages Independent Living (Tennessee, USA)²¹

¹⁹ Forbes, C., Inder, B and Raman, S. (2006) Measuring the cost of leaving care in Victoria, *Children Australia* 31 (3) 26-33.

²⁰ Ibid.

²¹ Erin Jacobs Valentine, Melanie Skemer and Mark E. Courtney, 'Becoming adults: One-year impact findings from the Youth Villages Transitional Living Evaluation' (MDRC: May 2015)

- Springboard (Victoria)²²
- Young People Leaving Care Support Service (NSW)²³
- CalYOUTH (USA) ²⁴

²² AHURI, 'Springboard evaluation report' (February 2015)

²³ Westwood Spice, 'NSW Homelessness Action Plan evaluation: Final evaluation report for project 2.22, Young People Leaving Care Support Service – North Coast' (Family and Community Services: February 2013)

²⁴ Mark Courtney et al., 'Findings from the California Youth Transitions to Adulthood Study (CalYOUTH): Conditions of Youth at Age 19' (Chapin Hall at the University of Chicago: 2016)

6 Social services

How could non-clinical mental health support services be better coordinated with clinical mental health services?

There is a significant opportunity to provide better mental health support (particularly in relation to prevention and early intervention) through better coordination with non-health services.

Given the extremely high risk, child and family services should be a specific focus for coordination and improvement. Other areas for consideration should include financial counselling and family violence and legal support services.

Are there significant service gaps for people with psychosocial disability who do not qualify for the NDIS? If so, what are they?

Limited access to allied health (e.g. speech therapy) and behavioural support services, especially for those families who are struggling to manage children with physical, mental or learning or behavioural difficulties but are not eligible for funded mental health or disability services. Anecdotal evidence from the families we work with suggests that NDIS is unavailable to many, and even those eligible for NDIS are experiencing lengthy delays in the development of case plans, and infrequent reviews.

What continuity of support are State and Territory Governments providing (or plan to provide) for people with a psychosocial disability who are ineligible for the NDIS?

No comment

Are the disability support pension, carer payment and carer allowance providing income support to those people with a mental illness, and their carers, who most need support? If not, what changes are needed?

No comment

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

No comment

How could mental illness-related income support payments better meet the needs of people whose capacity to work fluctuates over time?

No comment

7 Participation and inclusion

In what ways are governments (at any level) seeking to improve mental health by encouraging social participation and inclusion? What evidence is there that public investments in social participation and inclusion are delivering benefits that outweigh the costs?

No comment

What role do non-government organisations play in supporting mental health through social inclusion and participation, and what more should they do?

See comments below in relation to TEACHar.

Are there particular population sub-groups that are more at risk of mental ill-health due to inadequate social participation and inclusion? What, if anything, should be done to specifically target those groups?

Social participation and inclusion (and stigma) is a significant issue for young people in out of home care, and this impacts on their mental health.

Targeted, therapeutic trauma informed and strengths-based models of care in both health and social care sectors will assist with this. Also, targeted programs to address inclusion such as AV's TEACHar program (see section 10) are available and could be expanded.

What indicators are most useful to monitor progress in improving mental health outcomes through improved social participation and inclusion?

No comment.

8 Justice

What mental health supports earlier in life are most effective in reducing contact with the justice system?

A significant proportion of young offenders receive numerous other services and interventions (e.g. child protection, family, mental health, disability and homelessness services) before or during their involvement with Youth Justice. These young people also experienced challenges in education and health settings as well as in their families. Research and data shows that young people with mental health needs are significantly over-represented in justice systems, a significant proportion of young offenders have a disability compared with the general population, and substance misuse is a major issue for most Youth Justice clients²⁵.

Examples include Anglicare Victoria's Clean Slates: A health justice partnership project between Gippsland Community Legal Service and Latrobe Hospital's Community Mental Health Service. This involves the legal and mental health teams working together to both improve their own practice and ensure better accessible and timely access to legal services for people with mental health problems in the Latrobe region. The project is in its early stages but shows promise.

Strengthened intervention at these early service touchpoints that includes a focus on resilience, mental health promotion and early intervention, therefore, has the potential to reduce engagement with the justice system.

To what extent does inadequate identification of mental health and individual needs in different parts of the justice system increase the likelihood, and extent, of peoples' future interactions with that system?

²⁵ Ogloff, J and Armitage, P Youth Justice review and Strategy: meeting needs and reducing offending (2017) Victorian Government

Where are the gaps in mental health services for people in the justice system including while incarcerated?

Professor Ogloff and Penny Armitage in the review of youth justice system, released in 2017²⁶, clearly identified gaps in mental health services for young people in the Victorian justice system. AV supports the recommendations of this review in relation to mental health services, as well as further consideration of how youth justice reform more broadly can be oriented toward support and rehabilitation for young offenders.:

A disproportionate number of young people have mental illnesses, yet services are inadequate to meet their needs. The barriers experienced by all Victorians to obtain mental healthcare are compounded for young offenders who do not have priority access to services. Practice in the community is not consistent about managing mental health referrals at intake. Practice varies between offices and depends on the informal processes set up between services and Youth Justice.

Significant system limitations also exist for adolescent mental health services. Investigations by the Drugs and Crime Prevention Committee of Parliament (2009) and Victorian Ombudsman (2010) also recognised the need for a dedicated and secure adolescent mental health unit. Custodial facilities are ill equipped to deal with the mental health needs of young people because, unlike adult prisoners, children and young people in youth justice do not have access to designated facilities. Thus, young offenders with serious mental health issues are often held in custody, perhaps inappropriately. Youth Justice staff have few skills and limited training in this area.

Priority access to assessment and treatment should be considered for complex young offenders. The Review sees benefit in the availability of temporary assessment orders being made available to the Children's Court at the point of remand or release on bail that enables a young person to be subject to a compulsory assessment. There is also merit in considering a youth therapeutic order for court-mandated therapeutic treatment for young offenders. This has been proposed to address these deficiencies by Magistrate Bowles (2014) and the 'What can be done' Steering Committee.

What interventions in the justice system most effectively reduce the likelihood of re-offending, improve mental health and increase prospects for re-establishing contributing lives? What evidence is there about the long-term benefits and costs of these interventions?

In 2018 a partnership led by Anglicare Victoria was awarded a tender by Victoria Department of Justice to deliver the internationally sourced, evidence-based program Functional Family Therapy through Child Welfare (FFT-CW). FFT-CW will be provided in partnership with Mind Australia and Windana, will help families struggling with drug and alcohol problems, family violence, mental health issues, a history of abuse and neglect, criminal justice involvement or other parenting issues. It will provide practical help for families, to help them change their behaviour and deal differently with stressful situations.

²⁶ Ogloff, J and Armitage, P Youth Justice review and Strategy: meeting needs and reducing offending (2017) Victorian Government

What are the main barriers to lowering the over-representation of people living with a mental illness in the justice system and what strategies would best overcome them?

No comment

To what extent do inconsistent approaches across states and territories lead to inefficient, ineffective or inequitable outcomes for offenders and their families?

No comment

9 Child safety

What aspects of the child protection programs administered by the Australian, State and Territory Governments are the most effective in improving the mental health of people in contact with the child protection system?

The response of the child protection system to mental health issues is currently inadequate, and not reflective of the evidence on prevalence, risk and outcomes. Continuing to support the sector to building capacity in relation to mental health support for young people in care, including a strong focus on building strengths and resilience, is an important part of improving outcomes for this groups, and therefore reducing the costs associated with their high rates of service utilisation during and after their engagement with the system.

A greater focus on prevention and early intervention programs, particularly programs that work to strengthen family functioning and skills, will deliver significant outcomes in terms of mental health and wellbeing. These approaches should recognise that the best way to make a child safe is to make the family environment safe.

Anglicare Victoria is committed to the implementation and development of Evidence-Based Models (EBMs) in the Australian context, and continues to review programs delivered here and overseas to identify those that deliver outcomes most efficiently and effectively.

There are a number of EBMs in the child and family welfare field that have been shown to deliver positive outcomes in relation the mental health of participants.

We are delivering and measuring outcomes for Family Functional Therapy (FFT) and Family Functional Therapy Child Welfare in Victoria, including among cohorts of young people who have had contact with the justice system. Both of these models have a substantial international evidence-base supporting their implementation, including demonstrated positive impacts in relation to mental health.

Multi-systemic therapy (MST) has also been shown to have positive outcomes in international reviews, but is costly to deliver, and fidelity can be difficult to maintain given the workforce requirements. However, further investigation into long-term cost/benefit analysis of programs such as MST would be recommended.

What, if any, alternative approaches to child protection would achieve better mental health outcomes?

The child protection system needs to be oriented toward a strengths-based approach that maximises resilience, recovery and capacity building, and a to have genuine ambition for the young people in its care.

The observations made by Cree and Clapton in relation to child protection systems in the UK in 2009 remain relevant in Australia ten years later. That is, “for at least 30 years, public, political and professional focus has remained on the mechanisms of regulation rather than on the mechanisms of causation as far as child abuse is concerned”. There continues to be a default toward *post hoc* responses to failure - largely through compliance with standardised practice and procedure – rather than on identifying and addressing contributing factors, including poor family functioning and unaddressed issues of poor mental health.

The observations made by Cree and Clapton in relation to child protection systems in the UK in 2009 remain relevant in Australia ten years later. That is, “for at least 30 years, public, political and professional focus has remained on the mechanisms of regulation rather than on the mechanisms of causation as far as child abuse is concerned”. With timely and appropriate interventions, families who struggle can be supported to provide a safe environment for their children, and yet, proportionally, support for families before they come into contact with the child protection system is relatively under-resourced. In relation to mental health support specifically, the Mental Health of Children and Adolescents report confirms that even families that are seeking support struggle to find it, and that both parents and young people confirm that a focus on skills development is needed.

Models, tools, treatments and therapies that support personal and cultural change that are commonly employed at practice level in child and family welfare – including strong commitments to trauma-informed care and strengths-based interventions, can work to support and improve mental health and wellbeing. However, this focus is not strongly reflected in the way the child and family welfare system is conceptualised, structured, managed and monitored.

Leaving care

Despite high rates of homelessness, unemployment, and disengagement from work and school, Australian governments continue to under-resource skill development for young people in care and end-care at an arbitrary age ‘cut-off’, regardless of the young person’s readiness and ability to secure a home and support themselves. The way we allocate resources may successfully “protect” them from the individuals who harm them while they are in our care but provides very little protection at all from the risks associated with contemporary independent living.

Resourcing

Resourcing for the children’s and family services is a significant barrier to implementing the systemic change and embedded mental health support that could improve outcomes for children in care and their families. This directly contributes to missed opportunities to prevent and reduce harm, particularly in relation to ‘secondary’ and early intervention services. Some examples of where this lack of resourcing impacts on the capacity to provide timely and effective support for children and families include

- high case-loads preventing timely investigation and referral/intervention, meaning missed opportunities to provide earlier support for families (according to DHHS data, in 2017-18 an average of nearly 19.7% cases were unallocated at the end of each quarter)
- limited investment in prevention and early intervention services (in the form of family support). According to the Report on Government Services, family support expenditure nationally per child is about 15% of the cost of OOHC services per child (\$85.95 of \$616.98) , so successful intervention that minimises poor outcomes and the potentially traumatising need for further intervention represents a cost saving and a very positive return on investment. However, despite significant increases over the last decade, expenditure on family support and intensive family support comprises only 27% of Victoria's total expenditure on child protection services, and only 17% nationally.
- insufficient funding to provide therapeutic interventions to all children in residential care, despite evidence that that adopting a therapeutic model for all residential care settings would deliver much improved outcomes for young people.

10 Education and training

What are the key barriers to children and young people with mental ill health participating and engaging in education and training, and achieving good education outcomes?

No comment

Is there adequate support available for children and young people with mental ill health to re engage with education and training?

AV has developed the Transforming Educational Achievement for Children in Home-based and Residential care (TEACHaR) program to promote inclusion and re-engagement of young people in school.

TEACHaR is an intensive one-on-one program provided by Anglicare Victoria which sees trained teachers work with young people and their teachers to boost their academic achievement and engagement with school, so that they have the best chance of success in the future. Twenty teachers employed statewide by TEACHaR, which over the past year worked with 192 students and 481 teachers in 135 schools.

Children in out-of-home care often experience disrupted schooling, have lower levels of achievement and school completion rates and few go to university. TEACHaR works with students and teachers in all kinds of out-of-home care settings including foster, residential and kinship care – and all levels of schooling from primary to secondary and specialist settings. TEACHaR has been developed and established with the support of the philanthropic community and implemented with time-limited funding from the Victorian government.

It is unclear whether funding will be available past 2019.

Do students in all levels of education and training have access to adequate mental health-related support and education? If not, what are the gaps?

No comment

How effective are mental health related supports and programs in Australian education and training settings in providing support to students? How effective are programs in educating staff, students and families, on mental health and wellbeing? What interventions are most effective? What evidence exists to support your assessment?

No comment

Do teachers and other staff in schools and education facilities receive sufficient training on student mental health? Do they receive sufficient support and advice, including on the quality and suitability of different approaches, to adequately support students with mental ill-health?

No comment

What overseas practices for supporting mental health in education and training should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?

No comment

11 Government-funded employment support

How cost effective have the Australian Government's Disability Employment Service (DES) and Personal Helpers and Mentors service (PHaMs) been in enabling people with a mental illness to find and keep a job? Have the DES and PHaMs been targeted at the right populations?

No comment

What alternative approaches would better support people with a mental illness (whether episodic or not) to find and keep a job?

No comment

To what extent has the workforce participation of carers increased due to the Australian Government's Carers and Work Program?

No comment

What will the transition to the NDIS mean for those receiving employment support?

No comment

Which State or Territory Government programs have been found to be most effective in enabling people with a mental illness to find and keep a job? What evidence supports this?

No comment

How could employment outcomes for people experiencing mental ill-health be further improved?

No comment

12 General employment support to firms

What examples are there of employers using general disability support measures (through supported wages and assistance to provide workplace modifications) to employ people with a mental illness? How could such measures be made more effective to encourage employers to employ people with a mental illness?

No comment

Are there other support measures that would be equally or more cost effective, or deliver improved outcomes?

No comment

13 Mentally healthy workplaces

What types of workplace interventions do you recommend this inquiry explore as options to facilitate more mentally healthy workplaces? What are some of the advantages and disadvantages of the interventions; how would these be distributed between employers, workers and the wider community; and what evidence exists to support your views?

No comment

Are employers pursuing the potential gains from increased investment in workplace mental health which have been identified in past studies? If so, which employers are doing this and how? If not, why are the potential gains not being pursued by employers?

No comment

What are some practical ways that workplaces could be more flexible for carers of people with a mental illness? What examples are there of best practice and innovation by employers?

No comment

How can workplace interventions be adapted to increase their likelihood of having a net benefit for small businesses?

No comment

What role do industry associations, professional groups, governments and other parties currently play in supporting small businesses and other employers to make their workplaces mentally healthy? What more should they do?

No comment

What differences between sectors or industries should the Commission take account of in considering the scope for employers to make their workplaces more mentally healthy?

No comment

Are existing workers' compensation schemes adequate to deal with mental health problems in the workplace? How could workers' compensation arrangements, including insurance premiums, be made more reflective of the mental-health risk profile of workplaces?

No comment

What overseas practices for supporting mental health in workplaces should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?

No comment

14 Regulation of workplace health and safety

What, if any, changes do you recommend to workplace health and safety laws and regulations to improve mental health in workplaces? What evidence is there that the benefits would outweigh the costs?

No comment

What workplace characteristics increase the risk of mental ill-health among employees, and how should these risks be addressed by regulators and/or employers?

No comment

15 Coordination and integration

How effective are the governance and institutional arrangements for mental health in Australia in achieving the objectives agreed by COAG Health Council in the Fifth Plan? How can they be improved?

There is an opportunity to significantly strengthen coordination between health, mental health and non-health services. While employing locally focussed commissioning bodies may have potential to improve this, at present they remained focussed on specific parts of the system. PHN's, for example, may have potential to make improvements in this area, but their engagement with non-health services to date remains minimal.

To what extent do current governance and institutional arrangements promote coordination and integration of mental health services and supports across health and non-health sectors and different levels of government?

As noted above, discontinuity between disability, primary care and acute mental health services continues to be a significant structural weakness in the healthcare system, and many people – including many people at high risk of poor mental health outcomes – continue to “fall through the cracks” of systems driven by diagnosis-based eligibility criteria.

What are the barriers to achieving closer coordination of health, mental health and non-health services and how might these be overcome?

At local and state level, coordination and communication between acute mental health and other non-health, non-government services is limited.

While there are area-based initiatives and forums that seek to improve coordination, these tend to happen either across education and children's services, or across health services, but rarely both.

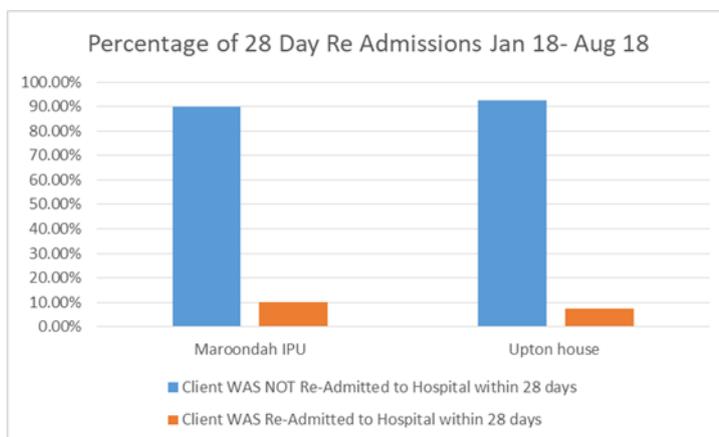
Also, there does not appear to be significant focus to date on utilising the potential of ‘front-line’ non-health services such as Anglicare to provide mental health support, prevention and early intervention (as well as more timely referral to specialist services where required) for population as high risk such as young people with experience of family violence or out of home care.

However, there are examples of effective partnerships between mental health and non-health services that could be more broadly applied, such as Anglicare Victoria’s Eastern Alcohol and Drug Program, and Eastern Health In Patient Units at Upton House and Maroondah. The Pilot involves a qualified Alcohol and Drug clinician being present on the ward with the objective of enhancing referrals to AOD programs, improving the engagement of referred individuals in their post-discharge treatment, and decreasing 28 day re-admission rates. Importantly, the approach also provides a more holistic support service for the patient’s family.

Currently, an Anglicare Victoria AOD clinician attends the wards numerous times a week. The clinician then works with ward staff to identify appropriate patients experiencing dual diagnosis issues, and works with the patient for the remainder of their stay, including:

- Providing an overview of the Alcohol and Other Drug Services available to the individual through Anglicare and other external services
- System Navigation
- Completion of preliminary assessment and measurement tools (K10, Audit, Dudit)
- Additional information regarding any family member or significant others that the individual wishes to have involved in their treatment, or whom they identified may benefit from being offered individual family support
- Immediate psycho-education, harm reduction and relapse prevention strategies
- Evaluation of where the individual is currently sitting within the cycle of change
- Consent to contact family members obtained
- Discharge date identified and first appointment booked for post discharge

The AOD clinician is often invited to attend the discharge meetings to provide Eastern Health staff with up to date patient information regarding their problematic drug or alcohol use, along with outcomes/recommendations, as well as provide an additional support for the patient.



Following discharge, the patient is able to access ongoing therapeutic support, as are any family members or significant others who may benefit from individual support to understand their loved one’s substance misuse, and develop skills and strategies to better support them.

Initial outcomes data has shown improved engagement of both patients and their family members, as well as a significant reduction in the number of 28 day readmissions.

Is the suite of documents that comprises the National Mental Health Strategy effectively guiding mental health reform? Does it provide government and non-government stakeholders with clear and coherent policy direction? If not, what changes could be made?

No comment

Are there aspects of mental health governance where roles and responsibilities are unclear or absent? Are the mechanisms for holding government decision-makers accountable for system performance sufficiently well-defined?

It appears that accountability continues to focus on delivery of particular services by particular branches of government. Anglicare Victoria is not aware of any effective accountability mechanisms that addresses for coordination and alignment across these service streams.

Population-based outcomes measurement, including measuring outcomes for high risk groups such as children, young people and families with contact with child and family services, may assist with this.

16 Funding arrangements

What have been the drivers of the growth in mental health expenditure in Australia? Are these same forces likely to continue driving expenditure growth in the future? What new drivers are likely to emerge in the future?

Insufficient investment in the services and programs that can support families and children at risk before significant mental health issues develop will contribute to ongoing growth in mental health expenditure.

Further it is AV's view that there remains insufficient data and research available on the extent to which better mental health support could reduce Australia's expenditure in relation to other significant cost items such as homelessness, justice and child and family services, including child protection. It is important to understand these interrelationships to ensure that interventions are provided as early and effectively as possible. In many cases, the most cost-effective point of intervention may not be the health system.

Can you provide specific examples of sub-optimal policy outcomes that result from any problems with existing funding arrangements?

How could funding arrangements be reformed to better incentivise service providers to deliver good outcomes, and facilitate coordination between government agencies and across tiers of government?

While the respective roles of the Australian government and State government in relation to mental health services is often clear, both levels of government are highly incentivised by the current system to 'gate-keep' entry into their respective systems (primary versus acute care) and ration access to them. There is little in the funding arrangements of the system to structurally incentivise approaches that deliver the best outcome for clients.

Are the current arrangements for commissioning and funding mental health services — such as through government departments, PHNs or non-government bodies — delivering the best outcomes for consumers? If not, how can they be improved?

How does the way the Medicare Benefits Scheme operate impact on the delivery of mental health services? What changes might deliver improved mental health outcomes?

What government services and payments beyond those directly targeted at mental health should this inquiry seek to quantify, and how should this be done?

17 Monitoring and reporting on outcomes

Are decision-making forums for mental health receiving high quality and timely information on which to base strategic decisions?

Decision making in relation to mental health would benefit by receiving a range of population level data that is much broader than the performance of, and access to specified mental health services. Mental health services only provide service to a very small proportion of the people in the population with poor mental health, and it is important that strategic decision-making is also informed by an understanding of who is *not* accessing these services, as well as who is.

Exposure to trauma in childhood has been referred to as ‘psychiatry’s biggest health challenge’²⁷, yet service responses, and comprehensive evaluations of their relative effectiveness, remain inadequate. National OOH standards specifically address the need to provide additional services to better address the mental health needs of children and young people in care. However, there remains a dearth of accessible, consolidated information and data to inform responses and assess how well mental health needs are being met.

A continuing focus on the development of client- and carer- defined outcomes, which focus on the impact on a person’s life experience and participation is also important, and is likely to correlate strongly with productivity outcomes for both people experiencing poor mental health and families, friends and informal carers.

In addition, it is hoped that the growing capacity across government to use linked datasets across portfolio areas will continue to strengthen understand of the impact of and inter-relationship other program areas with mental health issues.

Does Australia have adequate monitoring and reporting processes to assure compliance with national standards and international obligations?

No comment

Is there sufficient independence given to monitoring, reporting and analysing the performance of mental health services?

No comment

²⁷ Sara, G., and Lappin.J (2017) Childhood trauma: psychiatry’s greatest public health challenge? *Lancet public health* 2: e300-01

Which agency or agencies are best placed to administer measurement and reporting of outcomes?

No comment

What does improved participation, productivity and economic growth mean for consumers and carers? What outcomes should be measured and reported on?

What approaches to monitoring and reporting are implemented internationally? What can Australia learn from developments in other countries?

Investment in building the evidence-base is urgently needed if we are to improve mental health outcomes for young people who are in, or have been in care.

We know that mental health outcomes are poor for both children and young people in care, and adults who have experience of care in childhood, yet there is very little data available in Australia to measure or track these outcomes for this high-risk cohort. In fact, this population group is sometimes specifically excluded from collections such as *The Mental Health of Children and Adolescents* survey²⁸. The limited availability in Australia of specialist services or programs targeting the needs of care-experienced children and young people means that they are relatively invisible within mental health research and practice²⁹.

There is also “a clear argument for more comprehensive research examining the mental health of care leavers in Australia, particularly to inform leaving care and post-care service provision”³⁰.

Outcome measurement for this client group, either on a population or individual level, remains in its infancy, and largely separate from the way service delivery ‘quality’ is measured at a systems level. The latter remains focussed on compliance and throughput (e.g. no. of children and young people cared for) rather than on the benefits delivered in terms of those people’s welfare and well-being. For example, there is currently little outcomes data and benchmarking to evaluate the mental health outcomes and needs of young people who have left care.

Data analysis to better understand correlations and causes and antecedents of the poor mental health outcomes observed in care experienced children and young people is lacking. There is an opportunity to tap into ‘big data’ (including longitudinal analysis) to better understand people’s pathways into the system, and to identify earlier opportunities for intervention and prevention, within an appropriate ethical and privacy framework. This would also enable greater use of forecasting and trend analysis and strengthen and inform demand management and capacity planning.

To what extent is currently collected information used to improve service efficiency and effectiveness?

Models of mental health care for young people as a whole have not been well developed or adequately tested, neither across the age range nor across tiers of care³¹. In regard to the effectiveness of

²⁸ Australian Government (2015) op cit (see note on exclusions, p. 146)

²⁹ Tarren-Sweeny and Vetere (2013) references in Baidawi et al (2014) op cit.

³⁰ Baidawi et al op cit.

³¹ Newman, L., Birelson, P, (2012) Mental Health Planning for children and youth: is it developmentally appropriate? *Australian Psychiatry* 20: 91-97.

interventions, it is common for NGOs to self-fund evaluations of emerging practice and programs (including local adaptations of overseas-tested evidence-based programs) as there are few potential sources of funding to do this. Philanthropy often underestimates funds required for evaluation, and despite the obvious benefits for system-wide learning there is limited government funding available for non-health services. It remains the case that when negotiating costs with funding bodies, including governments, evaluation is often the first casualty.

Funding to support system-level research (e.g. system redesign projects, implementation studies, research to help identify most effective interventions for identified populations, testing collaborative versus integrated service delivery models, process redesign projects focussing on referral and service pathways) is extremely limited in Australia, particularly for service models and programs that are not based in health services. So, for example, there is limited local research to test the mental health impacts of therapeutic models of OOHHC, or on the potential for programs focussed on family support to improve mental health or to more effectively manage and mitigate the impact of mental illness.