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**Submission to the  
Productivity Commission's  
Draft Report on  
Mental Health**

**February 2020**

*[www.anglicare.asn.au](http://www.anglicare.asn.au)*

## About Anglicare Australia

Anglicare Australia is a network of independent local, state, national and international organisations that are linked to the Anglican Church and are joined by values of service, innovation, leadership and the Christian faith that every individual has intrinsic value. With a combined expenditure of \$1.82 billion, and a workforce of 20,500 staff and 9,000 volunteers, the Anglicare Australia Network contributes to more than 50 service areas in the Australian community. Our services are delivered to 450,000 people each year, reaching over 1.33 million Australians in total. Our services are delivered in partnership with people, the communities in which they live, and other like-minded organisations in those areas.

Anglicare Australia has as its Mission “partner with people, families and communities to build resilience, inclusion and justice.” Our first strategic goal charges us with reaching this by “influencing social and economic policy across Australia... informed by research and the practical experience of the Anglicare Australia Network.”

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## Introduction

Anglicare Australia acknowledges the work the Productivity Commission has devoted to its draft report. We commend the breadth of research and the detail in which the Commission has explored the social determinants of mental health, demographic features, social inclusion, and the need to address stigma, discrimination and disadvantage. This work will itself be valuable into the future.

Australia's mental health services have suffered from ad-hoc development and needless complexity. This stems from a lack of government leadership and investment over many years. We appreciate the Commission's attempts to repair this situation, and the resulting recommendations. However, the draft report and its recommendations do not offer a clear vision for a coherent mental health system.

It would appear that we, as a sector, did not explain clearly enough the key role of community services and voluntary organisations – the open ended support they offer, the opportunities they present, and the pathway to a recovery based approach. Nor have we articulated what it means to adopt a trauma-informed approach to care, which is the ground on which inclusive partnerships can be built. As a result there are major gaps between the Commission's data and the recommendations it makes – and the methods it recognises. Our first and most important request to the Commission is to address these gaps before in its final report, even if that means requesting more time from the Government.

Despite the Commission's review of population data, there are no recommendations on the social determinants of health. Anglicare Australia is particularly disappointed that the Commission has not considered the inadequacy of income support. In our view, this is not defensible. The links between poverty and poor mental health have been clearly established, and the evidence is now overwhelming that Australia's income payments are well below the poverty line.

In our first submission, we recommended that the Commission:

- Reflect on policy settings that impact the social determinants of health;
- Acknowledge the role of these settings in creating risks, such as chronic stress, which increases vulnerability to mental illnesses such as anxiety and depression; and
- Make recommendations to reduce this negative impact on mental health, such as increasing government income payments and the providing social housing.

Having achieved the first, we ask the Commission to reconsider our last two recommendations. We also ask the Commission to revisit our original submission in full, particularly Chapters 1-3. The remainder of this submission focuses on how critical services interface with mental health.

## Summary of recommendations

Anglicare Australia has made several recommendations across the draft report. These appear at the end of each relevant chapter, and are summarised below.

| Area                                       | Anglicare Australia recommends   |
|--|--|
| Community-based mental health services     | Increasing funding for community-based mental health services to meet demand, and ensure access for people without formal diagnosis.   |
| Community-based mental health services     | Drawing on evidence from community-based programs to determine system settings for mental health services across Australia.  |
| Community-based mental health services     | Funding mental health training for staff across the community sector, to embed trauma-informed practices and psychosocial support in service delivery models.  |
| Income support and employment services     | Increasing government income payments above the poverty line.  |
| Income support and employment services     | Providing crisis payments for people on low incomes who incur sudden costs for treatment.  |
| Income support and employment services     | Ensuring the consistent inclusion of employment aspirations and funding for specialist support for people with psychosocial disability through the NDIS.   |
| Housing and homelessness                   | Social housing and tenancy law reform, in accordance with the calls of the Everybody's Home campaign.  |
| Housing and homelessness                   | Increasing funding and providing flexible funding models to support mental health training for housing and homelessness services staff.  |
| Children, families, and early intervention | Adopting a systems approach to improving the mental health of children and families.   |
| Children, families, and early intervention | Increasing investment in services and programs that support families and children at risk.   |
| Children, families, and early intervention | Increasing funding and access to early intervention programs that address family function and skills through trauma-informed therapeutic approaches.   |
| Young people and the justice system        | Funding holistic, trauma-informed interventions and case management for young people experiencing mental illness who enter the justice system.   |
| Young people and the justice system        | Increasing funding for step up-step down programs. This should include transitional housing options to help people with mental illness avoid contact with the justice system. This must also include culturally appropriate options and services for Aboriginal and Torres Strait Islander people. |
| Young people and the justice system        | Adopting the recommendations made by the Change the Record campaign.   |
| Older people and aged care                 | Addressing mental health service gaps for older people through regional planning and clarification of state and federal responsibilities.  |
| Governance                                 | Ensuring all national mental health agreements and strategies include a principle of involving people, their families, and their carers in service design, governance and delivery.  |
| Governance                                 | Using agreements to embed recovery-informed approaches in funding and evaluation.  |
| Governance                                 | Reforming PHNs to deliver regional population-based commissioned mental health services. They must also be resourced properly to service rural and remote Australia.   |
| Governance                                 | Activity-based funding models are evaluated, and that hybrid models with block funding are considered.   |
| Governance                                 | Funding based on population needs analysis. This would lead to a major increase in funding for mental health services, including community-based services.   |
| Governance                                 | Adopting a funding model that enables psychosocial support for groups who do not have a diagnosis.   |

In addition, Anglicare Australia has taken positions on many recommendations included in the draft report. To assist the Commission with matching our recommendations, our positions are summarised below.

| <b>Recommendation</b>     | <b>Anglicare Australia’s position</b>  |
|---------------------------|--|
| Draft recommendation 10.2 | This recommendation is flawed and should be amended. Refer to page 24.                             |
| Draft recommendation 10.3 | This recommendation is flawed and should be amended. Refer to page 9; and page 24.                 |
| Draft recommendation 11.2 | This recommendation should be amended. Refer to page 22.   |
| Draft recommendation 11.3 | This recommendation should be amended. Refer to page 22.   |
| Draft recommendation 11.4 | We support this recommendation.  |
| Draft recommendation 11.5 | We support this recommendation.  |
| Draft recommendation 12.1 | We support this recommendation.  |
| Draft recommendation 12.2 | We support this recommendation.  |
| Draft recommendation 12.3 | We support this recommendation.  |
| Draft recommendation 14.1 | We support aspects of this recommendation, while others are flawed. Refer to page 14; and page 24. |
| Draft recommendation 14.2 | We support aspects of this recommendation, while others are flawed. Refer to page 14; and page 24. |
| Draft recommendation 14.3 | We support aspects of this recommendation, while others are flawed. Refer to page 14; and page 24. |
| Draft recommendation 14.4 | We support aspects of this recommendation, while others are flawed. Refer to page 14; and page 24. |
| Draft recommendation 15.1 | We support this recommendation and suggest it be extended. Refer to page 16.                       |
| Draft recommendation 15.2 | We support this recommendation and suggest it be extended. Refer to page 16.                       |
| Draft recommendation 16.4 | We support this recommendation and suggest it be extended. Refer to page 21.                       |
| Draft recommendation 17.1 | We support aspects of this recommendation. Refer to page 18.                                       |
| Draft recommendation 17.2 | We support aspects of this recommendation. Refer to page 18.                                       |
| Draft recommendation 21.1 | We support this recommendation.  |
| Draft recommendation 22.1 | We support this recommendation and suggest it be extended. Refer to page 25.                       |
| Draft recommendation 22.2 | We support this recommendation and suggest it be extended. Refer to page 25.                       |
| Draft recommendation 22.3 | We support this recommendation and suggest it be extended. Refer to page 25.                       |

## Nothing about us without us

Our thinking begins with the phrase “Nothing about us without us.” This is a claim for the active involvement of people in the decisions that affect them. More deeply, it is a call to create a society where we are all recognised and valued as whole people, not as problems to be solved. Our hope is that the final report focuses on designing systems of care in partnership with the people who use them. The draft report appears to endorse this approach in its overview, stating that:

*“Through the lens of participation and contribution, this inquiry examines how people with or at risk of mental ill-health can be enabled to reach their potential in life, have purpose and meaning, and contribute to the lives of others”.<sup>1</sup>*

The draft report acknowledges that this is as much about housing, friendship, work, and connection as it is access to suitable treatment and support. But the Commission has failed to put that understanding at the centre of its recommendations. And in spite of the above statement, the draft report has not recognised the system-wide reforms needed to support such a vision.

Instead, the Commission has focussed on improving access to clinical services. Although these services are critical, the report lacks a similar analysis of non-clinical services and the methods that underpin them. For example, the Commission barely discusses recovery, and does not seem to understand the importance of the recovery model. Recovery is referred to in Volume 1, but this is not accompanied by any recommendations. This is a major oversight given the recovery model underpins many mental health services, Particularly community-based mental health services. The recovery model is viewed as complimentary alongside any clinical treatment.<sup>2</sup>

Most community based mental health services across Australia take this recovery based approach, which means “being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues.”<sup>3</sup> For services, that means collaborating with people, their families and communities. It means focussing on wellbeing and helping to build positive links between people and the society around them. And it means offering people “a life in the community not defined by their mental illness.”<sup>4</sup>

This is supported by the findings of *Our Better Selves*, Anglicare Australia's 2019 State of the Family report.<sup>5</sup> It looked at appreciative inquiries conducted by five Anglicare teams across Australia. The inquiries found that programs cannot simply be about delivering services. They must also partner with people to achieve broader change. The Commission's draft report doesn't appear to consider change in this broader sense. This is a lost opportunity for the Commission to connect clinical services to every day support. Such an approach would help the Commission realise its vision of everyone being able to live a meaningful and contributing life, with or without mental health issues.

Mental wellbeing is deeply affected by the connections we can make, the security of our home, our access to support, and our capacity to learn.<sup>6</sup> The Commission has heard from many experts on the need to take a holistic approach to health and wellbeing which recognises that. Anglicare Australia's view is that community organisations in Australia can enable that holistic approach.

### **Community-based mental health services**

There are many definitions of community-based mental health services, and many are context-dependent. Anglicare Australia defines these as services that are not-for-profit, place-based, and encompass accessible clinical and non-clinical services that are in the community rather than a part of hospitals. They are guided by principles that align with those expressed by a recent position paper from similar services across Europe; that is, "high quality community-based mental health care:

- protects human rights;
- has a public health focus;
- supports service users in their recovery journey;
- makes use of effective interventions based on evidence and client goals;
- promotes a wide network of support in the community and;
- makes use of peer expertise in service design and delivery."<sup>7</sup>

These community-based services are critical when considering the 'missing middle' – that is, the lack of support for mental ill health that is between mild and severe. The draft report fails to grasp the role played by community-based services in filling the gaps between the primary and acute sectors. Nor is it clear if the Commission has understood the importance of allowing people to access such services without a clinical diagnosis. This access is crucial. Community-based services using the recovery model provide important tools to help people manage their mental illness so that they can live normal lives, and don't develop severe and enduring symptoms. Many of the people who access these services do not have a formal diagnosis, because they fear stigma and often cannot afford it. Insisting on a clinical diagnosis will see many people, particularly those on low incomes, miss out on vital support. It would also increase the demand for crisis services. We urge the Commission to revisit this gap, as there are no recommendations to fund or expand of these services to fill the missing middle.

### **Ensuring support, regardless of diagnosis**

In responding to the draft report, Anglicare Australia member St Bartholomew's House has noted that recovery and trauma-informed practices are being embedded across their transitional accommodation services. They note that "this has resulted in fewer evictions and increased capacity to support [people with mental illness] that do not meet the criteria for other transitional accommodation services e.g. due to alcohol or drug use or having a criminal record."

These practices meet a clear community need. 90 percent of clients surveyed by St Barts identified mental health issues as one of their main reasons for using homelessness and housing support services. Only 33 percent were diagnosed as living with a severe and persistent mental illness. Similarly, all of those in its women's service identified trauma as a factor that contributed to their homelessness. This has led St Barts to argue for funding agreements in housing that allow for recovery-oriented and trauma-informed service delivery. Anglicare WA has echoed this call across all community services.

As AnglicareSA found,<sup>8</sup> many clients with mild to moderate mental illness do not wish to take the steps necessary to establish a life-long diagnosis. Under current models, this makes it harder to ensure continuity of support. Anglicare Sydney, responding to the draft report, noted the cost associated with getting a formal diagnosis. This can make it inaccessible, especially given the general lack of access to psychiatric support. They argue that it is counterproductive to limit support to those with a formal medical diagnosis, and that people should be able to self-identify if they need help.

Our members have also emphasised that people should have access to a consistent caseworker. This option is not always available due to the fragmentation of funding across the sector. The absence of a consistent caseworker can exacerbate mental health symptoms and harm people's wellbeing as they retell their story repeatedly to different providers. We hope that **draft recommendation 10.3** on the development of single care plans will address this, but it is essential that funding structures include the flexibility and funds to support this model.

We are pleased that the report connects psychosocial support and other determinants of health. We remind the Commission that there needs to be an integrated model of service delivery to address the complexities behind mental health issues. Anglicare Sydney describes community-based mental health services as a unique offering in the marketplace, arguing that they supplement the clinical model and ensure consistency for the client.

### **The need for integrated support**

There are already models of a community mental health systems established in developed countries which are strengths-based and inclusionary. These models provide work and housing for people, rather than only targeted health care, and are cheaper to run than the systems that exist in Australia. Trieste Italy, with 24-hour community mental health services is a powerful example, as submissions to this inquiry show.<sup>9</sup> It continues to inspire programs in other countries. For example, a pilot based on the Trieste model of normalised community mental health services, housing, and employment will begin in Los Angeles this year.<sup>10 11</sup> Its key innovations are the introduction of *recovery-informed* funding, performance measurement, and wellbeing-focused services. This suggests a more positive and effective approach to community mental health services than activity-based funding.

None of this ambition is new to Australia. Across the Anglicare Australia Network, and the community sector more broadly, relational care has formed the basis of our work. The challenge is to shift away from a siloed approach to the wellbeing focus described above. That is why life experience, histories of trauma, poverty, and exclusion must inform care and support. The Commission would be aware of the trauma-informed approaches taken in areas such as housing, family, and foster care programs. These are not separate to mental health measures. They are integral to them.

This is also why the Commission's modest proposals to the rules around income support and housing allowances are so inadequate. Until people have enough income to live on and secure housing, then we cannot reach the goal the Commission has set. Anglicare Sydney notes that:

*"While the report recognises the complexity of causal effects surrounding primary mental health issues, it does not suggest a clear plan on how to address these complexities. We would like to see an integrated state and federal response that addresses the complex causal effects that lead to mental health issues and promotes a wellbeing model of mental health across the spectrum. The mental health care system needs to move away from siloed models of diagnosis and treatment and instead have one aligned response that transcends the boundaries of state and federal government jurisdiction where clients are provided with a seamless continuum of care. This continuum of care should provide crisis intervention and stop gap measures while also providing early intervention options that help prevent complex mental health issues developing in the first place. We need a wellbeing model that focuses on mental health from an early age."*

The Trieste model, for example, involves clinical services, community connection and social support. It includes housing, employment and psychosocial support. It is largely government run. In Australia, the community connections, services, and support are provided by non-government organisations (although most of these programs are publicly funded). Anglicare Australia believes that investing in these services can deliver a recovery oriented approach, and that the basic underpinnings of everyday living for us all demand public support.

We must become a society that welcomes the contributions and individuality of everyone, and supports people when they need it. All citizens must be recognised as whole people, not as a set of needs or conditions. Providing services through an outcomes-focussed lens, narrowed down to mental ill health, does not recognise us as whole people. For those us who experience severe and multiple disadvantages, a segmented approach simply does not work.

We must instead design systems that focus on wellbeing. Some of these services may be provided by mental health nurses, while others will come through the work of peers, mentors, housing support workers, literacy volunteers, and employers. We remind the Commission that almost all of Anglicare Australia's services involve challenges to people's wellbeing and mental health.

### **The National Disability Insurance Scheme and psychosocial support**

We warmly welcome **draft recommendation 12.1** for all levels of government to extend the funding cycle length for psychosocial supports from a one-year term to a minimum of five years. Our experience is that people find their own way of connecting to psychosocial supports, and their own way of drawing on them. They are relational. They can be as much about social change and community leadership as they are about individual wellbeing and health. They take time.

For example, A Place to Belong is a small organisation supported by Anglicare Southern Queensland that works to build inclusion for people who experience mental health challenges. In looking at the best of what they do (see *Our Better Selves*<sup>12</sup>), participants identified respect, love, safety, time, opportunity, leadership, and connection as critical aspects of their work. "A Place to Belong really respects and nurtures people. People value being respected." Leadership opportunities, exploration and personal growth all take time. An annual funding cycle works against developing the relationships that can lead to the transformation that A Place to Belong allows.

A Place to Belong's inquiry team also made the point that the very structure of the National Disability Insurance Scheme (NDIS) works against community inclusion, which is the organisation's core purpose. Anglicare Australia therefore supports **draft recommendation 12.2** and **draft recommendation 12.3**. As the draft report concludes, "In future, it is important that the Australian mental health system reaches a stage where regardless of their NDIS status, people are able to access the supports they need." Our surprise is that this does not appear to have been the goal of the National Disability Insurance Agency (NDIA), health systems, or governments until now.

The report's discussion of the broader psychosocial support programs – Partners in Recovery (PIR), Parents, Helpers and Mentors (PHAMS), and the Day to Day Living Program (D2DL) – is critical. Each of these programs plays a valuable role in funding the kind of support and inclusion that enables people to reach their potential in life. It beggars belief that the NDIS has evolved to put these programs and the people who use them at risk.

The draft report also points to the more fundamental problem of silos. While that creates difficulty for people within the health systems – as the introduction of the NDIS showed – it is a greater challenge more broadly. Recovery Point is a post-release drug and alcohol program run by the Samaritans Foundation in Newcastle. Poverty, homelessness, unemployment, drug and alcohol issues, as well as mental ill health, are factors in the lives of people who come to Recovery Point. There they support each other, build life skills, become mentors, peer workers, and good parents (see *Our Better Selves*<sup>13</sup>). This is as much about recovery, inclusion and autonomy as the psychosocial services focussed specifically on people living with a diagnosed mental illness. Across the Anglicare Australia Network, we take a recovery-led and trauma-informed approach to our work with people of all backgrounds and circumstances. We also look towards the enrichment they offer the wider communities in which they live. The goals of this inquiry are pertinent to almost all of the people and communities we work alongside. The silos that separate mental health from housing, justice, and out-of-home care are even more damaging than those within the health system.

The Productivity Commission should use the insights from this inquiry to imagine a more transformative approach to mental health and wellbeing. But it can't do that if it's not prepared to address the failures of the existing systems in terms of health, housing, income, and inclusion. Nor can these goals be realised unless the services themselves are non-judgemental, accessible and produced in partnership with the people who use them.

All of this points to the crucial place of community-based mental health services in any redesign of the system. *Recovery for all in the Community*, a recent European position paper on community-based mental health care,<sup>14</sup> identified the following six principles: Human rights; Public health; Recovery; Effectiveness of interventions; Community network of care and Peer expertise. It would be inspiring if the final report of this inquiry took a similar approach.

We hope to see the Commission recognise the capacity, flexibility, and effectiveness of community-based mental health services. Their focus on case management and holistic service support means that many of these services can demonstrate multiple benefits in a single case study – be it the value of place-based services, how to tailor support for particularly vulnerable groups, or the ability of community-based services to intervene effectively in times of crisis and implement recovery-based models of care.

**Recommendations**

Anglicare Australia recommends:

- Increasing funding for community-based mental health services to meet demand, and ensure access for people without formal diagnosis.
- Drawing on evidence from community-based programs to determine system settings for mental health services across Australia.
- Adopting a funding mental health training for staff across the community sector, to embed trauma-informed practices and psychosocial support in service delivery models.

## Income support and employment services

The Commission has recognised that even with the best clinical treatment, mental illness can result in the need for psychosocial and other support. This may include accommodation, income, and vocational support to assist people to live as independently as possible.<sup>15</sup> We commend in particular the Commission's broad exploration of social participation that goes beyond simply equating worth and meaning with the ability to obtain a job.

### Poverty, mental health, and out-of-pocket costs

We are saddened that the Commission's rich understanding appears to have been lost in the draft recommendations on income support and employment. Basic recognition of social determinants, such as poverty and stress, have also been ignored with the Commission refusing to consider the level of income support payments. The Commission's recommendations on employment services will be undermined if it continues to ignore the low levels of income support that consign people to poverty. Poverty is clearly linked to mental ill health, and consideration of income support is well within the scope of this inquiry. By glossing over the impact of poverty on mental health, the Commission is missing a major opportunity for deep reform. We will instead be left to tinker with a broken system that is damaging people's health and wellbeing.

We also ask the Commission to consider crisis payments for people who are mentally ill. Crisis payments, similar to those available for survivors of domestic violence, could allow people to access any medications they need to maintain good mental health. The costs associated with mental health treatment can be high. Those on low incomes are often forced to choose between taking their medication or paying for their essential living costs. This issue is relevant to the Commission's consideration of **information request 3.1** on out-of-pocket costs for mental health care.

These issues are also relevant to the Commission's consideration of the Better Access program. The Commission appears to assume that Better Access covers out-of-pocket costs. This is simply not true. It is typical for many psychologists to bill twice as much as the Medicare rebate, putting it beyond the reach of many people on low incomes. We support the Commission's recommendation for a full review of the Better Access program. This review should explore the typical out-of-pocket costs to people accessing psychological support.

### Reforming employment services

**Reform area 4** describes the ultimate goal for people with mental illness as getting into work. The draft report's discussion of Individual Placement Support (IPS) programs also focuses on the goal of reducing reliance on income support.<sup>16</sup> This is a narrow approach that does not align with the recovery model. Our members note that one of the biggest challenges for people with mental ill health is the pressure to re-enter the workforce before they are ready. The pressure to return to work can exacerbate symptoms, delaying a successful return to work. Anglicare Sydney describes recovery as "directed by the person, who dictates what recovery would look like for them and can include medication, therapy, daily exercise, coaching, social activities, working, and practising skills."

It is critical that recovery is directed by the person, not by a government trying to reduce spending on income support. As we noted in our first submission, economic participation may be a positive consequence of mental wellbeing, but it should not be the driver of community services or mental health programs. Again, we urge the Commission to recognise the importance of income support. It is critical that people are not forced to live in poverty while trying to recover and enter the workforce.

Anglicare Australia supports **draft recommendation 14.1**, and we recommend that it be extended. Centrelink staff must have the skills to stream jobseekers into the most appropriate employment services for them. Agencies in our Network find that some of their most vulnerable clients are placed on income support payments such as Newstart with limited recognition of their mental ill health and the impact this could have on their employment prospects. We also refer the Commission to our previous submission to this inquiry, and to our research on the need for more tailored employment services, found in our Jobs Availability Snapshot.<sup>17</sup>

Anglicare Australia supports aspects of **draft recommendation 14.2**, but cautions the Commission on aspects of it. Online peer group support could be valuable for many people and we support the inclusion of this in the Digital First Software. However, the use of face-to-face assessments as opposed to digital assessment should be flexible dependant on individual circumstances. Face-to-face interactions can create anxiety for some, while other jobseekers may benefit from the social interaction. Consideration should also be given to how this could effect jobseekers with episodic mental illness.

Anglicare Australia supports **draft recommendation 14.3**. Our network member, EPIC Assist, has been successfully delivering a model that bears close similarities to the IPS since 2015. The majority of referrals to EPIC originate from Centrelink and we support the Commission's recommendation that all unemployed clients of mental health services should be able to engage with the individualised employment services programs. EPIC supports the IPS Partnership Model, as Disability Employment Services are best placed to advise community mental health services. Anglicare Australia recommends that non-employed clients of mental health services have ongoing access to the program.

We are pleased that the Commission is exploring recommendations through **information request 14.2** on combining work and flexible income support. This approach is key to supporting people in accordance with the recovery model.<sup>18</sup> Work can provide people with purpose and helps them develop their identity, provide financial stability, and a sense of control over their future.<sup>19</sup> Any reform in this area must foster trust and clarity in jobseekers to ensure they know when and why income payments could be reduced or ceased. These measures must also ensure that people are not forced to work from fear of losing a payment, and prepare people if they need to transition back into payments.

The draft report supports the loss of eligibility for the Disability Support Pension (DSP) for those who work for more than 30 hours per week. Anglicare Australia strongly opposes measure, which ignores the complexity of recovery. Anglicare Australia does support, however, increasing the weekly hour limit to 38 hours.

**Recommendations**

Anglicare Australia recommends:

- Increasing government income payments above the poverty line.
- Providing crisis payments for people on low incomes who incur sudden costs for treatment.
- Ensuring the consistent inclusion of employment aspirations and funding for specialist support for people with psychosocial disability through the NDIS.

## Housing and homelessness

Anglicare Australia supports the Commission's recognition of secure social housing as critical to mental health. People living with mental ill health, including those who are homeless, should be assisted to find and maintain housing (**draft recommendations 15.1 and 15.2**). We welcome calls for better training for housing support services staff, and we emphasise that any training should help staff take a more holistic view of people's lives.

### The protective role of a home

Unfortunately, the draft report has failed to acknowledge the role that safe and stable housing plays in the prevention of mental health problems – particularly the role it can play in children's development. A home is more than a roof over a person's head. Without the stability and security of a home, it is much harder to take on the other challenges in a person's life.

The draft report has reflected on the Commission's recent work on affordable housing, but it has limited its scope to how housing stress affects those with severe mental illness. Housing security is fundamental to everyone's wellbeing, as we are deeply affected by the community connections we can make, the security of our home, and our access to support.<sup>20</sup> Housing disadvantage has been shown to harm mental health, and the effects may continue well after the situation improves. For example, living in an overcrowded house from birth to early childhood is associated with depression in midlife.<sup>21</sup> Given the scale of housing disadvantage in Australia, its role in driving poor mental health outcomes should concern us all. The scale of the problem means that many Australians could develop mental health issues related to, or worsened by, inadequate housing.<sup>22</sup>

A stable home provides the foundation on which to build care. Without this foundation, treatments are reduced to short-term, limited fixes.<sup>23</sup> For children, a stable home provides a sense of place to belong and feel safe, a base from which to attend school and engage with the local community. International research on the relationship between housing insecurity and child development shows how it can lead to poor social development across age groups.<sup>24</sup>

Research from the United States has found that housing insecurity is associated with poor health, lower weight, and developmental risk among young children.<sup>25</sup> Research by the Australian Housing and Urban Research Institute has found that insecure housing tenure affects children's socio-emotional outcomes, with frequent moves and renting both having negative impacts. Households experiencing housing stress were more likely to have poor socio-emotional outcomes, which shows that parental stresses can affect children.<sup>26</sup>

As our Rental Affordability Snapshot shows, the private rental market has completely failed to provide affordable and secure housing for hundreds of thousands of Australians.<sup>27</sup> This is worsened by private tenancy laws that allow no-cause evictions and stop people from making a home in their rental property, causing considerable stress.<sup>28</sup>

Ensuring that every Australian has a secure home would protect and improve mental wellbeing – and remove a cause of severe chronic stress for many thousands of Australians. We commend the evidence base and recommendations of the [Everybody's Home campaign](#) to the Commission.

### **Embedding mental health support in housing services**

Many of the services across our Network are not mental health-specific. However, all community-based services are potential mental health services. For example, it is essential to embed mental health support within housing services for young people to support those with increasingly complex needs. Mental health training and support is valuable for youth workers, case workers and financial counsellors, who are increasingly encountering mental health issues in their work. Such support should not replace specialised mental health services, but should work alongside them to provide people with the level of support they need in managing their lives.

Flexibility is also required with contracts and caseloads for non-mental health specific programs, recognising the time it takes to support people with complex mental health conditions. Given the high prevalence of mental health issues among young people experiencing homelessness, youth homelessness services should be supported to work with young people, even if this means foregoing short-term program goals, to achieve long-term benefits. For some non-mental health specific services, there can be a perverse incentive not to work with clients who have high mental health needs in order to meet their targets.

#### **Recommendations**

Anglicare Australia recommends:

- Social housing and tenancy law reform, in accordance with the calls of the Everybody's Home campaign.
- Increasing funding and providing flexible funding models to support mental health training for housing and homelessness services staff.

## Children, families, and early intervention

Timely support is the key to prevention and early intervention. Anglicare Australia supports the overall aims of **recommendations 17.1 and 17.2**. But although these recommendations for specific staff in schools to oversee child wellbeing and early screening seem well-intentioned, they may not be well-designed. We suggest investing in a trauma-informed framework for young children and their families. Again, this would lead back to community-based services. We have provided more evidence regarding early support and interventions for children and families below.

### Home visit programs

Neuroscience has offered us new understanding on how the developing brain is influenced by maternal deprivation and toxic stress in prenatal and infancy years. Research commissioned by the Victorian Government in 2015 also showed links between material deprivation and psychosocial wellbeing in early childhood. In circumstances of deprivation, even children with high levels of resilience can have poorer outcomes. Childhood wellbeing requires strategies that reduce the incidence and impact of childhood poverty.<sup>29</sup> As the second Australian Child and Adolescent Survey of Mental Health and Wellbeing has showed, children and young people in low-income families had higher rates of mental disorders in the previous twelve months.<sup>30</sup> It is important to understand these relationships to ensure that interventions are provided as early as possible. In many cases, the best point of intervention may be outside the health system.

One program setting out to address these challenges is the Nurse Family Partnership (NFP) from United States, built around nurses visiting low-income mothers at home from pregnancy until their children reach two years. It boasts a long track record of improving health outcomes. There are Australian equivalents to this program, such as the Australian Nurse-Family Partnership Program (ANFPP) and right@home. During the visits, the nurse helps the mother identify goals and develop strategies to achieve them. The visits provide a strengths-based approach which builds the mothers' capacity to identify solutions to problems. The mothers are empowered to work with their strengths, realise the power of their own actions, and gain a greater sense of control over their lives.

These and similar home-visiting programs must be expanded to improve the lives of more children and families living, while reducing out-of-pocket health and mental health costs. This should be part of a major investment in early childhood and family support. This should be a clear recommendation by the Productivity Commission.

These measures cannot be taken in isolation. Research on the Australian Nurse-Family Partnership Program for Aboriginal mothers and babies showed several challenges to program delivery. For example, housing conditions mean that around half of all 'home visits' could not be conducted in the home. They were held instead in staff cars or community locations. Together with exposure to violence, this undermined the program. Crises with the basics of living regularly intruded into the delivery of the program,<sup>31</sup> which again reinforces the need for the Commission to make recommendations on income support and housing.

## A whole of family approach

Prevention and early intervention approaches must recognise that mental health issues affect whole families, and that strong relationships are increase resilience. Data from The Mental Health of Children and Adolescents report shows the correlation between family functioning and poor mental health.<sup>32</sup>

*Table 1. 12-month prevalence of mental disorders among 4-17 year-olds by level of family functioning*

| Level of family functioning | Males (%) | Females (%) | Persons (%) |
|-----------------------------|-----------|-------------|-------------|
| Very good                   | 12.7      | 9.1         | 10.9        |
| Good                        | 16.7      | 13.8        | 15.3        |
| Fair                        | 25.3      | 13.5        | 19.7        |
| Poor                        | 36.4      | 33.8        | 35.3        |

The table shows that the prevalence of any mental disorders increased as family functioning decreased. Just over one third (35.3 percent) of young people in families with poor family functioning had a mental disorder, compared to 10.9 percent in those with very good family functioning.

Although the results do not establish causal relationships, they suggest that a strengthened focus on families could improve mental health outcomes. As our member organisation Anglicare Victoria emphasised, it is important to go beyond the traditional focus on one-on-one clinical relationships and consider the context of family and culture. This is particularly important where mental health issues coexist with financial hardship, violent behaviour in the home, or a lack of parenting skills and effective child care.

### Recommendations

Anglicare Australia recommends:

- Adopting a systems approach to improving the mental health of children and families.
- Increasing investment in services and programs that support families and children at risk.
- Increasing funding and access to early intervention programs that address family function and skills through trauma-informed therapeutic approaches.

## Young people and the justice system

The nexus of justice and mental health reflects the social determinants of mental health keenly. We welcome the Commission's recognition of the importance of early intervention and ensuring links to the community for continuity of care on release. There is patchy access to community-based mental health services for people at risk of offending and those who have been released from the justice system.

Anglicare Australia endorses **draft finding 16.1**. We would also welcome research on best practice and targeted interventions. We ask the Commission to refer to our section on early interventions for children and families facing adversity. It is crucial to start at the earliest point possible, and at the same time, providing a safety net for people to change their own trajectory.

We note that **draft finding 16.2** recognises the need for community-based mental health services across the spectrum from mild to subacute illness, as recommended in other parts of our submission. Anglicare Australia agrees with **draft finding 16.3**. An additional intervention to help those in contact with the criminal justice system would be to raise the minimum age of criminal responsibility to at least 14 years. We call on the Commission support this call, which would divert many young Australians ending up in our criminal justice system. Of particular concern are Aboriginal and Torres Strait Islander young people, who are disproportionately represented.

Anglicare Australia notes the importance of community-based services before their release, such as financial counselling and housing support. There should be no release from the justice system into the community without suitable continuity of support, including housing.

Anglicare Australia notes the Commission's **information request 16.1** on transition support for those with mental illness released from the justice system. [Samaritans Recovery Point](#) is a program run by our Network member, The Samaritans Foundation, which provides practical assistance and support to people who are leaving prison or alcohol and drug rehabilitation centres to re-engage with the community. This includes assisting with finding accommodation, clothing, opening a bank account and looking for work.

Some people supported by Recovery Point have had housing issues before they enter prison. Almost all of those in the program have housing as their number one priority after release. As one program worker said, "a lot of essential things need to be done when someone comes out of prison, like applying for a birth certificate, ID and housing. It should really be done while they're inside. Getting a housing application to go live in the system takes about four weeks. Imagine if that was done before the person is released." This highlights the need to change systems so that people can better prepare for their release.

Several Anglicare Australia Network members provide transitional support programs, and we are happy to put the Commission in touch with them for additional information. These transitional programs are essential, but they must be accompanied by support during vulnerable period of reintegration into the community so that people can be supported for the long-term.

Anglicare Australia endorses **draft recommendation 16.4**. We ask the Commission to include a recommendation that Aboriginal and Torres Strait Islander Peoples be given proper support, including access to culturally appropriate housing, prior to their release.

Finally, there is a clear need for all of these recommendations to form part of a National Youth Justice Plan. This call has been made by Change the Record, a coalition of Aboriginal and Torres Strait Islander, human rights, legal, and community organisations asking for urgent action to close the gap in imprisonment rates for Aboriginal and Torres Strait Islander people.<sup>33</sup> This should be acknowledged by the Commission.

#### **Recommendations**

Anglicare Australia recommends:

- Funding holistic, trauma-informed interventions and case management for young people experiencing mental illness who enter the justice system.
- Increasing funding for step up-step down programs. This should include transitional housing options to help people with mental illness avoid contact with the justice system. This must also include culturally appropriate options and services for Aboriginal and Torres Strait Islander people.
- Adopting the recommendations made by the Change the Record campaign.

## Older people and aged care

There is little acknowledgement in the draft recommendations of the difficulties older Australians experience accessing community mental health services. This is especially true for those on low incomes who have complex and chronic conditions, or are experiencing mental ill health between mild and acute. Our Network has found that community mental health services for older people, while highly valued by recipients and organisations, are under resourced and overwhelmed. Waiting times for mental health programs such as Aged Persons Mental Health Team (APMHT) can be lengthy and tend to prioritise people with acute issues or who are in crisis. Services like these are also geographically patchy, which shows the need for regional planning with community mental health services front of mind.

Early intervention, as identified by the Commission under **reform area 1**, can and should apply to older people during life transitions. We also know that that the online nature of many self-help programs may not be suited to older people who prefer face-to-face services. Anglicare Sydney has observed that older people express a need for shorter appointments, options for face-to-face or phone services, group work, and community access support. Older people also report that they like consistent workers and need longer transitions from one service offering or worker to another. Preferences such as these must be taken into consideration when planning services for older people.

### The role of doctors

Anglicare Australia supports **draft recommendation 11.5** to improve mental health training for doctors. We suggest that particular attention be paid to training on mental ill health in older people. This includes both doctors in the community and doctors who work in aged care facilities. Mental illness is often unrecognised and untreated by families and health care professionals. When GPs do recognise mental illness in their older patients, they are often given medication alone due to the lack of accessible mental health services.

### Mental health in aged care facilities

As noted in our previous submission, members in our Network have had difficulty accessing psychogeriatric practitioners and mental health staff in aged care facilities. We support the provision of more mental health nurses and psychiatrists in aged care facilities. We note, however, that this is not reflected in **draft recommendations 11.2 and 11.3**. We also re-iterate the need for mental health training for aged care staff. Aged care facilities need to be better funded to work with mental health professionals and support clients with mental ill health. Staff in aged care facilities must be appropriately skilled to do this.

### Home care and mental health support

Anglicare Sydney has called for mental health investment for people in home care, alongside investments in residential aged care. They have identified a gap in service provision for those who are over 64 but not living in a residential aged care facility. For people aged over 65 mental health falls under the umbrella of aged care, while other are often ineligible for treatment or will not seek help. We believe there is a role for community-based mental health services to fill this gap. Anglicare

Sydney are currently delivering a promising two-pronged approach to address this gap. In addition to supporting older people in the community, they are also providing capacity building for aged care staff and family members.

We urge the Commission to include access to community mental health for all ages in its recommendations reiterate that those in home care should not become a low priority for mental health services. Services should be resourced to provide for all who need them. We also note the social and mental health benefits of receipt of a timely Home Care Package. The waiting list remains unacceptably long and is putting stress on older people and their families.

**Recommendation**

Anglicare Australia recommends addressing mental health service gaps for older people through regional planning and clarification of state and federal responsibilities.

## Navigation platforms and pathways

There are multiple service interfaces with mental health, meaning that navigation plays a key role. With regard to **draft recommendation 10.2**, we do not understand why the Commission has identified Centrelink as outside of the scope of navigation platforms. The welfare system is a key point of intersection for people with mental ill health. Its exclusion as a navigation platform flies in the face of accountability, consistency, and 'a no wrong door' approach.

The Anglicare Australia Network has witnessed growing challenges with Centrelink services. If clients serviced by our Network are claiming income support, they are at a high risk of having problems with their claim. Clients with mental health issues, and those who do not understand how to navigate automated technologies, are severely impacted. The decreasing levels of face-to-face contact means that Centrelink staff are now even less likely to identify acute needs and make referrals for additional support. As well as the direct impact on the lives of Centrelink customers, these issues are creating a ripple effect where problems with Centrelink escalate along with demand for other support services. These include family support, housing and homelessness, alcohol and drugs, mental health, aged care, disability services, emergency relief, and crisis services. They also include healthcare providers and the justice system.<sup>34</sup> Issues with Centrelink are a roadblock to a well-functioning, person-centred mental health system. Beyond **draft recommendations 14.1 – 14.4**, the Commission should consider how Centrelink can be reformed so that it no longer undermines the mental health of those who depend on it.

Those working in health and non-health pathways need to be resourced to do the work that navigation platforms create. This includes clinicians, health care providers, schools, aged care facilities, Indigenous service providers. It is unclear whether this system is predicated on all organisations that can use navigation platforms hiring clinical staff. Anglicare Australia calls on the Commission to consider how this recommendation will interact with the single care plan mechanism under **draft recommendation 10.3**, as the direction of both mechanisms to one person could complicate a siloed system. We are pleased to see holistic services being envisaged as part of potential single care plans, and we urge the Commission to call for the resourcing of such services for people on low incomes.

## Governance

Anglicare Australia commends the merits of local, population-based service planning. We support the Commission's sentiment around expanding public community mental health services, but are concerned the draft recommendations don't reflect this desire in practice, beyond providing some financial incentives to the states and territories as part of the Renovate and Rebuild models.

Anglicare Australia supports **draft recommendation 11.4** on strengthening the peer workforce. We recommend the introduction of tighter requirements and qualifications for those employed as peer workers, as well as better wage and employment conditions. Guidelines and professional development should recognise that experience of a mental health issue does not mean one can fully understand another person's experience. In applying the recovery model, peer workers must recognise that recovery can look different for different people. Anglicare Sydney also cautions that working with people with complex mental health issues may serve as a trigger for the peer worker's own mental health issues. This needs to be addressed in the governance of peer workers. It is also important to ensure that a peer workforce is balanced by staff with clinical and other relevant expertise.

We also support **draft recommendation 21.1** on universal access to aftercare. In terms of governance, we ask the Commission to consider mechanisms to ensure this principle is applied consistently, such as through tied funding and detailed reporting or being enshrined in legislation. We see an opportunity for this measure to be provided alongside services enacting the 'no exits into homelessness' measure. This could streamline support for some of the most vulnerable people experiencing mental ill health.

Anglicare Australia also endorses **draft recommendations 22.1, 22.2, and 22.3** but believes they should go further. We would welcome the opportunity to work with the Productivity Commission to develop the proposed agreement on suicide prevention and whole-of-government mental health strategy. We can also put the Commission in touch with Anglicare Australia member programs to help develop carer support measures.

## Renovate and Rebuild models

With regard to the two new governance models offered by the draft report, we are cautious about creating a new bureaucracy to administer mental health as favoured by the Commission. Building new bureaucracies takes time and expense, and we do not believe it is necessary to achieve reform. The established Primary Health Networks (PHNs), for example, could be more easily changed to ensure they are fit for purpose. This would also avoid the risk of mental health and other primary health services becoming separated. Our members' experience with PHNs is mixed. Some have found that they are too large to tailor services to the region. Local providers are often cut out of the commissioning process where contracts go to larger providers. When local providers are rewarded contracts, PHN requirements can be burdensome.

Anglicare Australia supports regional planning and mapping in a way that focuses on local place-based solutions. The PHNs overall are a good model that can be reformed to achieve this consistently. An obvious change is to increase the number of PHNs so that they are better tailored to specific and manageable regions, and can commission place-based programs and engage with all providers more effectively. Our recommendations below to make the actions of PHNs less prescriptive would also assist PHNs in playing the role they were designed for, as would the commissioning of services that aren't purely clinical or contingent on a formal diagnosis.

### **Activity-based funding**

Some of the proposed changes to the funding models assume that a service provider will absorb management and on-costs. However for a service to provide quality practice, ensure compliance with all standards, and be effective in service delivery, funding models need to cover costs for effective management and governance. Current funding could put people at risk as organisations come under financial stress to meet requirements, or are forced to self-fund quality services. We ask the Commission to consider risks of moving to an activity-based funding model and seek the Commission's reflection on the following questions:

- In what way does mental health lend itself to activity-based funding models in the same way as hospital funding has been developed?
- Who decides what is necessary for each client, and what will be the criteria for these decisions?
- Will activity-based funding be flexible enough to respond to the episodic and sporadic nature of mental health?
- Will service providers be expected to absorb the costs of administration and supervision?

### **Supporting people without a formal diagnosis**

One of our most pressing concerns is that the Commission has overlooked recommendations from across the sector to support people without a formal diagnosis. Our members work with many people who with mental ill health, yet only a small percentage are diagnosed as living with a severe and persistent mental illness. For some, the cost associated with getting a formal diagnosis makes it inaccessible. This can reduce accessibility for some people and effect mental wellbeing, especially for those who are waiting for publicly funded psychiatric support. Anglicare Australia supports a person-centred model that treats people with dignity and respect, whether they have a formal diagnosis or not. In any governance model, psychosocial services must be available with no formal diagnoses of recipients. We recommend that PHNs are empowered to commission community-based mental health services that are open to people without a formal diagnosis.

### **Tying Medicare rebates to funding**

We are very concerned that in both funding models suggested by the Commission, the volume of Medicare rebates will be used to determine the level state and territory mental health funding. This method is deeply flawed. Rather than deriving funding based on population needs analysis, it constrains funding to the demand generated by a small part of the population. These are typically those who are educated, based in cities and are experiencing mild mental ill health.

This is confounding given the Commission's concerns relating to marginalised groups, who are the least likely to use rebated mental health services. This is also important for those without a diagnosis. There are entire cohorts, typically those on low incomes, who do not register in the figures. This issue should also be at the forefront of the Commission's consideration of **information request 3.1** on out-of-pocket costs for mental health care.

### **Services for Aboriginal and Torres Strait Islander People**

Anglicare Australia is pleased to see that mental health among Aboriginal and Torres Strait Islander people is a priority for the Commission. We agree that there needs to be greater community input and culturally appropriate mental health services.

We support increasing community control and call for increased investment in Aboriginal-specific services, especially in light of the role these services can play in mental health and suicide prevention. Progress in this area should involve Aboriginal and Torres Strait Islander people contributing to service design and delivery to help build systems that recognise the importance of culture. These may include cultural strengthening activities as an important part of healing. It is particularly critical that Indigenous-led clinical expertise in suicide prevention is included in program design and implementation. We refer the Commission to the work of Adjunct Professor Tracy Westerman.<sup>35</sup>

### **Rural and remote services**

The PHNs can be a cornerstone for providing place-based population assessments, commissioning integrated mental health services that match need. However they must be adequately resourced, geographically appropriate to represent the needs of rural and remote communities, and not limited to medical models of intervention. Remote and rural mental health services need a major boost in funding to recognise the low level of active providers, and need to create continuity and sustainability of service. While telehealth can assist with some stages of mental health support, it is not a replacement for desperately needed face-to-face mental health services in rural and remote Australia.

#### **Recommendations**

Anglicare Australia recommends:

- Ensuring all national mental health agreements and strategies include a principle of involving people, their families, and their carers in service design, governance and delivery.
- Using agreements to embed recovery-informed approaches in funding and evaluation.
- Reforming PHNs to deliver regional population-based commissioned mental health services. They must also be resourced properly to service rural and remote Australia.
- Activity-based funding models are evaluated, and that hybrid models with block funding are considered.
- Funding based on population needs analysis. This would lead to a major increase in funding for mental health services, including community-based services.
- Sustainable funding for community-based mental health services to ensure they meet demand.
- A funding model that enables psychosocial support for groups who do not have a diagnosis.

## Conclusion

Anglicare Australia welcomes the opportunity to shape the Productivity Commission's final report on mental health. Our expertise rests in working in partnership with people and communities. Ours is a network of national strength and local connections. As our submission shows, almost every one of our services has a link to mental health, whether it is a post release drug and alcohol program in Newcastle, a family counselling service in Sydney, or an aged care and homelessness service in Perth.

Anglicare Australia believes that best practice public policy development is iterative, and we have approached our response in that spirit. Our response focuses on system-level weaknesses, however, we again emphasise our gratitude to the Commission for the ambition and scope of its work.

Funding and embedding community-based mental health services are a key priority for Anglicare Australia. Our submission has argued that this should be partnered with mental health training for staff in key mainstream services. Providing mental health training for staff across the mainstream health and community services, and for human services such as employment services and Centrelink staff, would support people with mental illness in mainstream services. It would also increase the rate of referral to specialist support. When people with mental illness experience prejudice and uninformed responses in mainstream services, it increases their risk of losing access to those services. It also reduces their chances of referral to specialist help and increases their experience of stigma. There have been countless opportunities to address these yawning gaps. Instead, governments have preferred to fund public awareness campaigns, which have had little success.

The Commission must also recognise the role of social determinants in its recommendations, not just in the report's discussion. The costs of mental illness are not distributed equally, and nor is access to support. As our member organisation Brotherhood of St Laurence's emphasised in their own submission to the Commission's issues paper:

*"Australia will not shift the dial on mental illness, unless we simultaneously address levels of poverty and social exclusion, which predispose people to mental illness, and can aggravate and intensify the experience of it".*

Our hope is that the Commission will recognise this in its final recommendations. This approach would make this inquiry a turning point for mental health in Australia, and mark the beginning of a much needed change across our systems.

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