

Anglicare Sydney Submission to the Productivity Commission Inquiry: The Social and Economic Benefits of Improving Mental Health



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1. OVERVIEW OF ANGLICARE SYDNEY

Anglicare Sydney is a not-for-profit organisation of the Anglican Church and one of the largest Christian community service organisations in Australia. Anglicare was formed on 1 July 2016 by the merger of Anglicare Sydney and Anglican Retirement Villages. Anglicare exists to serve people in need in our community, enrich lives, and share the love of Jesus. We respect and value every person as made in the image of the living God. We seek to serve those who are ageing, vulnerable or marginalised by meeting their material, physical, emotional, social and spiritual needs. In partnership with Anglican parishes and others, we provide a range of services that promote dignity, safety, participation and wellbeing for people in their relationships, homes and communities.

We operate a wide range of community and aged care programs across the Sydney Metropolitan, the Blue Mountains, Illawarra and Shoalhaven regions of New South Wales. Anglicare has an annual revenue of \$343m and assets of \$1,734m. Our 3,900 staff and more than 3,000 volunteers operate across a diverse range of community services including: foster care and adoption services; early intervention family support; counselling and family support services; Family Relationship Centres; residential and community aged care services; retirement village living; services for migrants and refugees; carer support services; disability respite; mental health support; youth services; emergency relief for people in crisis; social and affordable housing; opportunity shops providing low-cost clothing; emergency management in times of natural disaster; and chaplains in hospitals, prisons, mental health facilities and juvenile justice institutions.

2. ANGLICARE'S MENTAL HEALTH SERVICES

Anglicare's Mental Health Services (MHS) have been operating for more than 20 years in the Greater Sydney and Illawarra region. The service is underpinned by the knowledge that mental health is shaped by various social, economic and physical environments (social determinants of health), operating at different stages of life. Our services subscribe to the National Standards for Mental Health Services (2010) and the National Practice Standards for the Mental Health Workforce (2013), underpinned by Recovery Oriented principles. These principles provide the overarching context and guide for mental health reform and service provision which requires a shift away from illness management and diagnosis to recovery, empowerment, social inclusion and lifelong learning, to guide policy direction and services.

Supporting mental health and wellbeing is a common thread across all of Anglicare Sydney's services and is characterised by:

- **Direct service delivery** – specific mental health programs, including Personal Helpers and Mentors (PHaMS), National Disability Insurance Scheme (NDIS), Partners in Recovery (PIR), Individual and Family Counselling, and Family and Youth programs. People with a mental illness also represent a significant proportion of our Community and Aged Care services. We take a preventative and early intervention approach to mental illness and respond to crisis where necessary.
- **Partnerships and joined-up responses** – contributing to the development of integrated social services that include establishing linkages internally and externally, and engaging with local providers, local Churches and community groups.
- **Advocacy and education** – with individuals, communities and at the policy level.
- **Mobilisation of a diverse workforce** – including its staff, volunteers and supports across diverse backgrounds and communities in order to respond to complexity of need and support mental wellbeing.

It is within this context that Anglicare Sydney welcomes the opportunity to respond to the Productivity Commission's Inquiry. This submission draws on the insights and experience of our work in supporting people along the life cycle of mental illness and, more broadly, in areas where we are seeking to break cycles of disadvantage and vulnerability, and supporting people at life changing points such as re-settlement and ageing.

3. GENERAL OBSERVATIONS

Anglicare Sydney would like to make a few general observations:

1. **The current mental healthcare system can be viewed as a medical model**, which is often deficit-based and crisis driven. It is not necessarily recovery oriented and trauma informed, and, increasingly, reflects a business/private practice model, leaving less time for relational, quality and compassionate care.
2. **Services need to be person centred** – how mental health services can support individuals in the achievement of their priorities should inform the development and improvement of the mental health sector. This should be supported by a whole of life approach and step in/step out service system, characterised by: supporting the person holistically, service integration, seamless pathways, consistent and evidence based professional practice, training and professional development, and high quality, peer-led models supported by technical expertise and skills development.
3. **Greater investment is required in prevention and early intervention services**, such as psychosocial support services. There is evidence that when treated early, mental illness is less severe and of shorter duration, and less likely to recur. Anglicare's experience highlights that the first 4 weeks of service intervention is critical in building functional capacity and promoting recovery. This requires a service that people can step in (and out of) when they need it, provides access to casework which is committed to strengths base practices, and provides less administrative bureaucracy. Currently, there is too much focus on paperwork and proving eligibility, which is both repetitive and time intensive.
4. **Policy and funding needs to focus on recovery model approaches** including continuation of successful peer-based and group recovery models.
5. **Individually based funding arrangements need to be supplemented with more holistic models of care**. Rather than building trust, rapport and capacity, such funding models can lead to dependency and an unequal power dynamic between the provider and clients, increasing the risk for and vulnerability of some cohorts, particularly those who are socially isolated. Clients and their carers give constant feedback about the importance of access to case management and having a service that listens and walks alongside people.
6. **There are still major barriers for people accessing mental health supports**, including: siloed service models (especially when transitioning from youth mental health to adult services, and from adult to aged care services); costs of accessing mental health services including lack of both non-fee-paying and bulk billing services; eligibility and having to prove yourself unwell to access and maintain service levels (eg NDIS).
7. **There are current gaps in the mental health system for people with less severe mental health and episodic mental health**; for example, people who need 'low touch'

(low intensity) support services over the life cycle (ie borderline personality disorder and post-traumatic stress require longer term, regular supports); people in regional areas, especially in smaller towns with less than 500 people; and youth specific mental health programs.

8. **There is a continued need for community-based block funded mental health services** which support the largest number of people with a mental illness. They provide support, compassion and continuity across the spectrum of mental illness, helping to keep people socially connected, assisting them to manage their illness and reducing the demand on acute tertiary health systems.
9. **There is still significant under-resourcing in rural and remote areas** in mental health crisis and early interventions services. Issues have been exacerbated as a result of the drought and the family relationship breakdown issues this has caused.
10. **Measurement of outcomes in mental health programs is important** - Anglicare Sydney's outcomes-based evaluation framework, incorporating the Personal Wellbeing Index (PWI), provides a way to understand and measure the extent to which our mental health services are making a positive difference to people across *all* life domains thus contributing to an evidence base of best practice.

The following section draws on the insights of Anglicare Sydney's practitioners and lessons learned, incorporating case studies from our services.

4. EARLY INTERVENTION AND PREVENTION – SOME MODELS THAT WORK

4.1 Psychosocial support services and the NDIS

Community based, psychosocial support services are extremely effective in supporting people with complex mental health issues resulting in both improved wellbeing and participation in the community. These enable people to maintain a consistent and close relationship with the service, particularly when the participant attends 2-3 times a week. Such services combine both one-to-one and group work, fostering environments that enable a shift away from managing a person's care and treatment to that of supporting self-management and efficacy, using the recovery oriented model of care. The model allows the service provider to adopt a flexible and agile approach, supporting engagement by incorporating both education and coaching, and delivered by a workforce that is 'compassionate and caring', thus reducing the need for hospitalisation.

Anglicare Sydney has been providing psychosocial support services since 2008 under the Personal Helpers and Mentors Program (PHaMS), currently transitioning clients to the NDIS. It is an evidence based recovery model to support people in managing their mental illnesses. The program focuses on 2 areas:

1. Core supports focusing on a participant completing activities of daily living, enabling them to work towards their goals.
2. Capacity building which focuses on helping participants build their independence and skills.

These supports are provided in one-on-one sessions and group work, with a focus on increasing participant capacity to live independently. Support Categories include daily living, home, health and well-being, lifelong learning, social and community participation, relationships, and choice and control.

Psychosocial supports case study

Participant X has been engaged with Anglicare's Mental Health Service (AMHS) for 6 years. Her first mental health episode occurred as a teenager and, after leaving school, she experienced a significant decline in her mental health and her functioning, and was diagnosed with schizophrenia, depression and anxiety. As a result, she dropped out of her university course. Although she entered the workforce for some time, she again found the impact of her mental health difficult to manage and she found herself out of a job. Participant X is currently unable to work due to the complexity of her health issues. She receives a Disability Support pension and resides in a FACS Housing property.

Participant X engaged in a number of psychosocial supports focused on self-esteem, communication skills, assertiveness, maintaining relationships, motivation, habit building, attending therapy appointments, connecting to support groups, attending recreation activities (such as art galleries, drama group, public library) , managing complex physical health and the impact on MH symptoms, relapse prevention, strategies to manage anxiety, researching Medicare rebates for a variety of therapies and other medical needs, and building skills to use public transport.

During her engagement with AMHS, Participant X was connected to a movie group, afternoon tea events and other interest groups. A death in X's family resulted in an increased level of distress and an immediate risk assessment response was undertaken by Anglicare, supported by provision of mental health first aid, linking her back into a counselling service and reconnecting with friends. A decline in physical health and changed personal circumstances resulted in increased supports being put in place and referrals to a community based dietician and financial and tenancy support assistance. Following a further relapse, Anglicare linked Participant X to the clinical supports needed to facilitate a referral to a clozapine clinic.

Despite these setbacks, Participant X has engaged in education, and employment skills and training such as attending Barista Training, working with art gallery owners to display her works, and digital literacy training.

The agility and holistic, recovery-oriented nature of the service meant that in times of relative wellness, the participant could still receive relevant yet reduced support, and during times of ill-mental health, access to more intensive, tailored supports to help maintain wellness and avoid a hospital stay. A professional worker provided continuity of care and support coordination, using strengths-based and trauma-informed practice.

Participant X has been advised she is eligible for NDIS, however, no support coordination has been provided. Unable to engage in the complex task of activating her plan on her own, the participant remains in our service and is awaiting the outcome of her NDIS review request.

Participants themselves indicated what they valued in their mental health services in an evaluation of psycho-social supports carried out by Anglicare Sydney in 2017. These included:

- **Supports to cope with life** – 72% felt they needed support in managing the complexities of daily living.

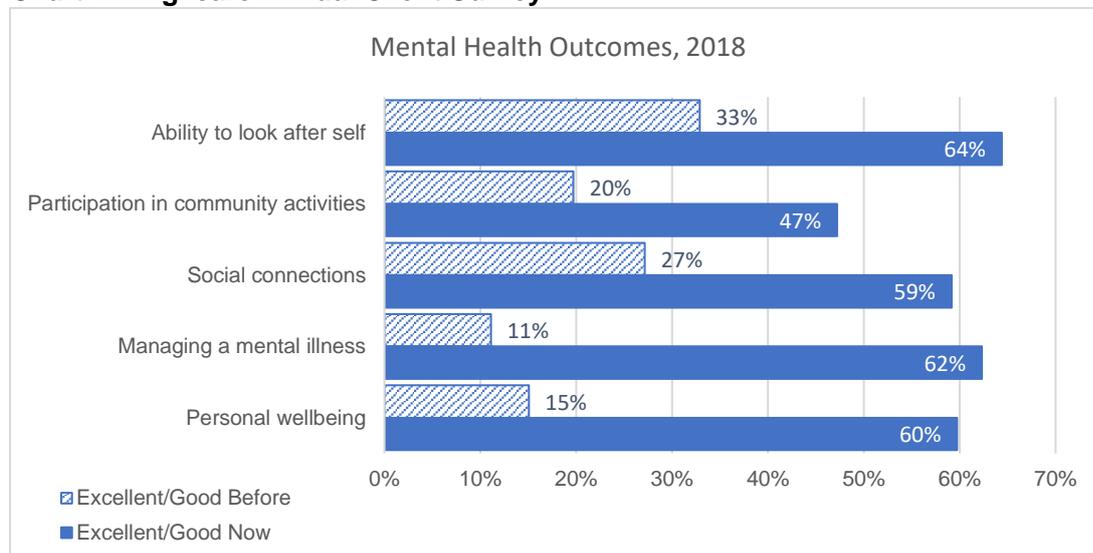
- **Skills Building** –72% were positive about the need for skills building, particularly in the areas of financial management, saving, budgeting and support for everyday skills such as shopping, attending appointments and taking part in social activities.
- **Supports for social connection and Support Coordination** – 84% indicated participation in social activities and making friends was a critical element for people experiencing mental health challenges. Areas of greatest need were seen in supports to attend recreational activities, attending such activities in a group setting, social skills development, and coordination of supports for this purpose.

The transition from the previously block-funded mental health services under PHaMS to NDIS packages over the last 12 months has been challenging both for clients and as a provider:

- The focus appears to be shifting from a recovery based support model to ‘maintenance’;
- There is a strong transactional nature to the new model with complex eligibility and assessment criteria;
- The flexibility of the old model is being lost as is the ability of clients to self-refer when they are experiencing difficulties;
- There are fewer opportunities to spend time and build trust with the client which was a critical and essential element in the old model;
- In order to sustain the financial model workers are poorly remunerated for the level of work required, leading to poorer quality outcomes in the service;
- NDIS clients are experiencing issues with service navigation;
- The prescriptive nature of the funding model acts as a constraint on what supports can and cannot be provided;
- Anglicare staff have expressed concerns about the adequacy of the assessments being undertaken by the LAC;
- There is a lack of reporting templates back to the Department.

Anglicare has conducted two surveys of its mental health services (in 2017 and 2018) which demonstrate positive outcomes for clients. Findings include substantial improvement reported across all outcomes – managing their illness (+51%), personal wellbeing (+45%), participation in community activities (+27%), social connections (+32%) and ability to look after oneself (+31%) (see Chart 1).

Chart 1: Anglicare Annual Client Survey



However, the two surveys took place during the transition phase to the NDIS and, what is apparent, is a reduction in positive outcomes, as PHaMS clients transition out and NDIS clients transition in. Clients in 2018 were less likely to report improvements to their situation with a substantial drop in improvements in social connections, from 71% reporting improvements in 2017 to just 50% in 2018. There was also a drop in improved participation in community activities from 63% to 49%, although this change only just failed to achieve statistical significance ($p < 0.07$).

4.2 Family Mental Health Support Services

A good practice model in the delivery of mental health supports for families is the Family Mental Health Support Services (FMHSS) model funded by the Department of Social Services. The model provides early intervention support to children and young people who are showing early signs of or are at risk of developing a mental illness, with their families and carers assisting in support. The model is currently delivered by a range of community based services around Australia, including Anglicare Sydney. The strength of this model is the use of a family-centred approach that places the child or young person at the heart of the program, with compulsory participation of the parent/s. The service is designed to address risk factors and strengthen protective factors. The service incorporates a mix of early intervention and brokerage arrangements and flexibility of funding that is tailored and practical. The community based mental health service provider works closely with the sub-acute mental health services.

Anglicare FMHSS Practitioner reflections:

'It is not uncommon for people to contact our service and request "please fix my child" (in this example, involving a young person with an eating disorder). In this service it is critical and compulsory that the family is involved. This allows us to get a holistic view of the child'.

'A young person presented with a mental health issue. During a child counselling session, it emerged that the young person's struggles with depression stemmed from her worry about her parents fighting and relationship. The parents were engaged in adult counselling, had access to a caseworker, and a family dispute resolution practitioner was engaged. Our service was flexible and wrapped around the whole family'.

4.3 Peer education and peer support group activities

Promoting strategies such as peer education and peer support group activities enables clients and their families to learn new ways to manage mental health issues, to identify their own goals, aspirations and life options, and to share that journey with others, all of which supports an early intervention approach.

Peer-to-peer strategies are a key component of Anglicare mental health services and have proven particularly effective in engaging people from culturally diverse backgrounds, people accessing our psychosocial services, and for carers looking after someone with a mental illness. In our experience, peer support groups and group activities open up options to support people with mental illness quite quickly following initial referrals and self-referral to a service. These can be delivered in community settings and places where people naturally gather to meet.

In Anglicare's Northern Inland region, the delivery of the new Psychosocial Support Service Activity will actively engage with groups not already engaged in wellbeing initiatives due to work and family commitments (eg. working mothers). It is envisaged that the group component will incorporate

topics of interest (including nutrition, meditation/relaxation techniques) alongside the one-on-one counselling/coaching.

The Commonwealth Carer Respite and Carelink Centre (CRCC) model in South West Sydney/Nepean region has used peer programs extensively over the years to support carers looking after someone with a mental illness. Using a community capacity building model, our service has supported the initial establishment and facilitation of the groups, over time supporting the groups to be self-managing and self-sufficient, thus not only supporting social connectedness and peer to peer learning, but ensuring this is done in way that does not '*create artificial environments ... but restores the natural connections to self, community and disengagement from support structures.*'¹ (ADD reference)

It has been our experience that peer programs for carers living in regional areas are currently lacking. Community based services have the potential to support particular cohort design and establish community based peer models to support community wellbeing. As carer support services transition to the new Integrated Carer Support Services (ICSS), Anglicare is acutely aware that some services are already pulling out of the provision of peer support programs, and indeed carer supports more broadly.

4.4 Integrated service models

The importance of service integration, particularly for families who are vulnerable and at risk, has long been recognised. A 2010 study commissioned by FaHCSIA noted that families with multiple needs often accessed a range of uncoordinated services; many families only accessed those that provided basic needs supports such as food, housing and clothing but did not access early intervention or prevention programs.²

Instead, funding contracts can be siloed and some services are only selectively available – eg. aimed at a specific issue such as financial relief, parenting, family counselling, mental health. The evidence of success in Anglicare's Family Support Integrated Service Delivery Model suggests that an integrated service model can be a feasible and effective way forward in supporting service engagement and providing person-centred, holistic and continuity of care for people who are experiencing vulnerability.

For people presenting with mental health issues many of the traditional barriers to service access could be addressed in an integrated model that provides:

- block funded services so cost is not a barrier to participation;
- comprehensive intake approach so that people only have to tell their story once and complexity can be identified early;
- a case management approach that supports the implementation and ongoing re-sequencing of programs or interventions that wrap around the individual;
- streamlined processes.

Since 2011, Anglicare Sydney has been operating an Integrated Service Delivery (ISD) model at its sites at Liverpool and Sadleir in South West Sydney. The focus is on early intervention and crisis support. A current study by Anglicare Sydney (to be launched in May 2019) has found that

¹ Glover, Helen. (2012). Recovery, Lifelong Learning, Empowerment and Social Inclusion: Is a New Paradigm Emerging? pp.15-35

² Macarthur M, Thomson L, Winkworth G and Kate Butler (2010) *Families' Experience of Services*, Occasional Paper, Institute of Child Protection Studies, Australian Catholic University. p5

the ISD model has increased family resilience, and led to increased confidence and competence in parenting and improved financial behaviours.

4.5 Co Design - Working with communities and stakeholders

In some program areas, Anglicare Sydney is increasingly adopting a co-design approach to review and re-design/design services with, and for, community members. An example of this is our work with carers looking after a family member with a mental illness. This cohort has become increasingly concerned with the potential lack of supports available to carers under the NDIS and as a result of the reforms to the carer support service system. Implementation of a co-design process is being undertaken to design a continuity of support program to ensure carers of a person with a mental illness are adequately supported during this period.

Community based organisations are well placed to facilitate community capacity building activities. This involves, for example:

- Investment and development of social connections models – for Anglicare Sydney this is achieved through strong parish partnerships and supporting the active role of volunteers in supporting community wellbeing.
- Promoting mental wellbeing in natural, yet strategic ‘touch points’ in local communities, eg. Anglicare Op shops and mobile community pantries. These ‘points’ are not just about selling goods or providing low cost food; they act as ‘bridge builders’ involving community volunteers and staff who can provide social and emotional support, and act as a referral point into mental health and other services.
- Investment in place based, mental health awareness raising and promotional activities to reduce the stigma of mental health, and educate professionals and community members to listen to and consider ways of supporting people with a mental illness. Anglicare has facilitated some significant work in its region aimed at increasing community understanding of the impacts of trauma, re-settlement and dementia on mental health. Much of this work is unfunded, but critical in engaging people and communities in strengthening and supporting their own communities and mental health.

Case study – co-design and increasing social connectedness to support mental wellbeing of carers

A Program Manager heard that a large group of CALD carers wanted to learn to use technology to manage their stress associated with their caring role and improve their ability to care for their family members. The 'quick fix' could have been for the manager to run an 8 week, off-the-shelf technology program. Instead he negotiated with local, ethno-specific groups to utilise Anglicare's resources alongside the community resources to:

- 1. run a series of co-design workshops with local community members to design a locally based technology program;*
- 2. engage local community members to support the engagement of the broader community in the program; and*
- 3. help facilitate the programs.*

Anglicare was the silent partner, creating an opportunity for clients accessing our services to be part of a broader 'community', learning program delivered for and by the community. This created new social connections and new learning, that might not had been realised if the group was created just for the 'client' of the service.

Whilst focused on the carer, not the care recipient, this example demonstrates how community-based services and practices can be re-shaped to enable broader social inclusion, meaningful learning and a sense of community for vulnerable people, 'outside' of the service delivery world.

5. CLINICAL AND CRISIS SUPPORTS

While supporting early intervention and prevention, Anglicare Sydney continues to support and respond to people presenting in crisis. For a person experiencing a psychotic episode, Anglicare Sydney staff report that people are sometimes being turned away from hospital or released prematurely. As a service provider, we encourage a short, voluntary engagement with the mental health facility in this situation, knowing that the only other pathway for that person involves the Police. It is during these times that it is absolutely critical that people have access to an advocate; otherwise they are at risk of being turned away or being detained. There have been a number of instances where advocates have not been invited in or involved.

Appropriate assessment needs to ensure that people presenting with suicide ideation gain admission. However, the acute hospital setting can be a traumatic experience for people with mental illness, compounding their existing life trauma and this can adversely impact their willingness to seek treatment. In some cases, the hospital setting can trigger a range of adverse reactions across a range of conditions so consideration needs to be given as to how the therapeutic setting supports people with significant mental health illnesses and episodes.

Case study – crisis support in regional areas

We often work with episodic mental health issues. If you call the MH Helpline, you often wait at least 30 minutes for a response. You can call an ambulance, but then there is often a 3-4 hour wait for a psychiatric triage. There are no qualified people to do this in regional towns, and the person with the mental health issue will often just 'take off'.

6. MENTAL HEALTH AND AT-RISK POPULATIONS

Across the broad sweep of Anglicare Sydney programs there is evidence of a number of sub-groups of the population who are vulnerable in the area of mental health – children and young people, carers, the homeless, the elderly and refugees. Each of these sub-groups requires targeted and significant mental health supports.

6.1 Children and Young People

In 2017-18 more than 19,000 children and young people were in out-of-home care (OOHC) in NSW.³ It is well recognised that these children and young people are a highly vulnerable group with increased physical, mental and social health needs and often limited access to services and support. Anglicare Sydney currently provides OOHC services, in the areas of Foster Care, Adoption Services, Family Preservation and Restoration Service throughout Metropolitan Sydney to families and young people experiencing disjointed family environments, reduced cognitive and physical functioning and trauma, and social exclusion, which can all contribute to poor mental health.

It is Anglicare Sydney's view that a medically-oriented, mental health model does not adequately meet the needs of the children and young people in OOHC. The current system is characterised by a lack of therapeutic interventions, flawed psychological assessments and an absence of formal diagnosis for certain conditions such as behavioural disorder and post-traumatic stress, neither of which are recognised under the NDIS. Misdiagnosis and lack of understanding of these conditions can lead to misdirected funding. Significant investment needs to be made to support increasing mental health needs of children and their families in the OOHC system.

It is also critical that other systems in which children and people interact (eg schools and higher education) are less rigid in their approach to supporting young people experiencing mental health issues. For example, schooling is often not a high priority for people experiencing mental illness (especially if they experience anxiety and depression), yet there is often family, societal and systemic pressure to attend regularly, achieve and socialise. Education settings could provide a safe and more supportive environment through delivery of alternative classes, such as life skills, learning and scaffolding that builds on the present and real experiences being faced by the individual and offering greater flexibility during assessment stages.

³ Australian Institute of Health and Welfare 2019. Child Protection Australia: 2017–18. Child welfare series no. 70. Cat. no. CWS 65. Canberra: AIHW.

An OOHC multidisciplinary approach to supporting whole of family

Anglicare's OOHC service has recently established an in-house clinical care team aimed at providing a compassionate, wrap-around service for young people and their families engaged in three NSW Government funded services: Foster Carer, Adoption Services, and Family Preservation and Restoration Service. A multidisciplinary team consisting of a clinical worker (Psychiatrist, OT) a therapeutic worker (counsellor) and community workers utilise evidence based, therapeutic child and adult focused interventions, and facilitate referrals. The team works in the school, home and community settings. The model has been established in response to the court driven, deficit based approach deployed in the OOHC sector and the often fragmented service journey experienced by the young person and/or family.

6.2 Carers

Anglicare has been providing carer support services for over 30 years, with the aim of building carer confidence and coping skills, alleviating stress and anxiety and building sustainability. We work alongside carers to help them navigate the support systems and facilitate pathways to supports, including respite, peer support and counselling. Feeling acknowledged and valued in the community are essential to carers.

Our service experience has highlighted that carer stress and anxiety as a result of looking after someone with a mental health issue, can be alleviated through the provision of respite, practical help and support with information, access to peer support groups and, in some cases, counselling. Some of the most significant outcomes for carers supporting someone with a mental illness have come from working in formalised partnerships with other community based mental health services. The transition to the NDIS means many of these supports will now be de-funded. An example of this is the Haven Project below:

*The **Haven Project** funded by the Department of Social Services was a service for carers who are supporting someone with a mental illness/or autism. It involved five organisations, including Anglicare Sydney to provide a family focused, resilient model of care that linked carers to services and wellness activities based on goals and individual strengths. The model assisted carers and their families to navigate the NDIS systems and processes, whilst facilitating community awareness on mental health and the impacts of mental illness on carers and families. Positive outcomes for participants included: improved social connections, increased skills and knowledge relating to their caring role; increased personal wellbeing as a result of accessing educational, social and recreational activities such as gardening and cooking; and reduced stress and anxiety through support to navigate services.*

In operation for almost 10 years, funding for the Haven Project ceases this year, representing a significant loss of community based mental health supports.

Anglicare welcomes the introduction of the Integrated Carer Support Service (ICSS) in September this year, and its focus on early intervention and prevention, and availability of respite and financial packages support. It also supports the recent announcement that the Continuity of Support measure for carers looking after someone with a mental illness has been extended. However, there remains some uncertainty, and indeed anxiety within the carer population, as to how the new

funding will continue to support respite (unless emergency) and carer wellbeing with its emphasis on on-line, and the appropriateness of new supports such as coaching (especially for CALD and disconnected, ageing carers).

Anglicare Sydney's own research and experience emphasises the importance of respite in supporting carers' social, emotional, physical, learning and cultural needs.⁴ We commend the Victorian State Government's investment in carer respite alongside the Federal investment.

Carers regularly report that health care systems, including hospitals and GPs, do not adequately support carers since the current health system is geared towards the care recipients. The NDIS has presented additional challenges for carers supporting a family member. Mental illness is not well understood, and caring for someone with a mental illness and its impacts, less so. Carers often report that their support needs are often ignored by health and NDIS staff, and GPs do not know how to 'interact' with the NDIS system to support care recipient and carer.

Carers who are combining work and care suggest that flexible working arrangements can mitigate reductions in working hours for carers and should be promoted. For those who opt for temporarily leaving the workforce for caring purposes, training and employment support programs might facilitate their transition back into the workforce, however, due to heavy caring commitments, there is, in our experience, often a low uptake.

Some health professionals and carers have suggested that carers need more support in developing pre-employment resources, including an 'audit' to document the valuable skills and knowledge carers hold. This could be facilitated by a family support/peer support worker model role. Others have suggested that the caring role itself needs to undergo an upskilling so that carers feel confident and assisting in their caring role, with skills learnt transferable into more formal employment settings (eg. in mental health first aid, running meetings, advocacy).

Carer support needs are not static. Awareness of, and confidence in, the system of assessment, referral and service delivery is critical if mental health care recipients and their carers are to receive timely and appropriate support. Effective and ongoing engagement and communication with carers, including those who may have become disconnected for any number of reasons including disability, age, cultural background, social or financial disadvantage, or the circumstances that can be associated with full-time provision of care, presents a major challenge. On-line gateways and supports alone cannot address this challenge, but requires place based, culturally appropriate and community based approaches.

Anglicare carers advocate for the creation of a carer framework for the health care system care that facilitates early intervention for both carers and care recipients who are in need of formal support. Suggested components of the framework include: a system navigator /case management role that supports and influences the carers interface with the health setting (eg. hospitals) and additional resource development that supports GPs and health services to understand carers' needs and available support services.

When working with carers, Anglicare Sydney supports a co-designed, carer-led approach to the implementation, design, delivery and review of future carer services. Such an approach has already demonstrated positive carer and organisational benefits, including service improvements, strengthening of the carer's voice and enhanced community and stakeholder understanding and buy-in of the issues, experiences and potential for involvement.

⁴ Kemp, B., King, S., Paleologos, Z., Bellamy, J. & Mollenhauer, J. (2016) Carers Doing it Tough, Doing it Well, Anglicare Diocese of Sydney, Social Policy and Research Unit

6.3 Housing, homelessness and mental health

Anglicare delivers a range of housing models working with young people at risk of homelessness, rental accommodation for people in financial need and transitional housing for vulnerable groups. Anglicare has also partnered with the NSW Government to provide 550 social and affordable housing properties for older people, to be delivered over the next 3 years. The model will include the provision of wrap-around services, including mental health and social supports. Many of our housing programs have demonstrated a range of success factors and good practice principles, which could be further explored in the context of supporting mental health outcomes.

Reconnect

This service is funded by the DSS and operates in over 100 sites across Australia. The program offers ongoing support to young people aged 12-18 years, who are homeless or are at risk of homelessness, and works with both the individual and their families to resolve conflict and restore relationships. Over 40% of people presenting to this program do so because of mental health reasons (ACS Survey 2017) and family relationship breakdown. 84% of participants reported improved outcomes and 83% reported their needs had been met as result of participating in Reconnect.

The strength of this program is that it allows us to work with each person according to their particular needs and situations, and offers a range of supports including counselling, mediation, employment, accommodation, legal and health services, dealing with Centrelink and reconciliation. 'It is a relationship intervention, not just about housing stability' (Anglicare Manager).

Whilst at the Federal level, the investment and viability of this service has often been subject to review and critique, it is Anglicare's view that the program's evidence based principles, targeted interventions and associated positive outcomes, positions this program as a highly effective, youth focused, early intervention program, particularly for those presenting with mental health issues.

People with complex and persistent mental health issues require assistance with tenancy support. Even with accommodation stability, many people live in 'environmental neglect' (eg. hoarding and squalor). They often require ongoing and intensive support to maintain their home (eg. developing skills in basic home and security management, hoarding and squalor education, managing visitors – especially those who are preying on the person's vulnerability).

Housing support for a young person in OOHC is challenging. Placements can often break down as the young person gets older. There is often nowhere for this young person to go, and they are forced to go into a residential care facility.

An Anglicare housing service example

Anglicare Sydney's Support and Housing Initiative for Families in Transition (SHIFT) transitional housing program provides families fleeing domestic violence and refugees with low-cost, short-term housing. The model operates without government funding. Property owners lease their investment properties to Anglicare for 2-5 years. Over a period of 12-18 months, occupants are supported to find stable accommodation in the private and /or public housing market. The local community church and community members partner with Anglicare to provide practical, spiritual and community supports, and assist families to access other Anglicare and government services. The model provides practical supports and friendships, and provides the community with opportunities to learn and grown in their capacity to care for vulnerable families.

6.4 Mental health and the ageing

As part of the Anglicare Australia Network, Anglicare Sydney and other Anglicare agencies have contributed to a broader discussion on mental health and the ageing for the purposes of this Inquiry. Details of this discussion can be found within the Anglicare Australia submission to this Inquiry.

However, as a provider of home care services supporting over 5000 people, we also draw the Commission's attention to the following local issues and impacts that have been drawn from our local home care service experience in Greater Sydney and the Blue Mountains in relation to mental health and the elderly living at home.

1. Home Care Packages (HCP) are not currently geared towards clients who are experiencing mental illness, especially chronic mental illness. Availability and easy access to mental health services for older people with mental illness is often lacking, and these people's complex needs are not being adequately met by the mental health, general health or aged care sectors.
2. It is often difficult to differentiate between symptoms of dementia and a mental illness, and it is important for assessors to be able to make that distinction since the interventions can be very different. Additionally, there can be the presence of both a mental illness and dementia.
3. There needs to be closer working relationship between aged care and mental health providers, acknowledging the need for both to collaborate to achieve the best outcomes for clients.
4. Both the Home Care and Mental Health sectors need more agility in responding to the episodic nature of mental illness. For an elderly person experiencing suicide ideation or at significant risk of self-harm it is often difficult to get the involvement of the relevant mental health teams since this can be observed as an aged care concern. There is no delineation of responsibility between the State Government (acute sector) and the Federal Government (Aged Care sector). This fragmented interface puts more pressure on families and carers. In some instance, lack of access to mental health services is a factor in determining the ability of an older person to continue to be cared for at home.

Mental Health and the Ageing – Case Studies

Case Study 1: A new Home Care Package client with a long history of mental illness and substance abuse was referred to Anglicare Home Care Services. There was a very poor handover from the mental health case-manager who didn't return calls or provide support to either the client or to us through the transition. This client was living in poor and unsafe conditions (eg. no locks, people walking into her home at all hours, no fridge). HCP provided locks on the front door, and a new fridge, assisted her with appointments, food shopping and advocacy with Department of Housing to repair and maintain her home. During this time, the mental health service exited the woman from their service without consultation. Anglicare's home care service continued to work with her for 2 months, but her circumstances barely improved and she was moved into a residential facility. There may have been a different outcome if mental health services continued to provide the necessary interventions and supports.

Case Study 2: A man on a home care package was living with a squalor and hoarding condition, poor hygiene and environmental neglect, and at risk of tenancy eviction. The community mental health team refused to accept his referral as they deemed that he was not at immediate risk of harm and did not have a formal diagnosis. How do you get a formal diagnosis if the services don't accept the referral?

Anglicare also notes that many clients and their families do not have the understanding or insight that is needed in relation to mental health services. Many have been living with this condition most of their life, supported by family members who themselves lack knowledge of the services and supports available to the care recipient and the carer. With the introduction of the NDIS the number of mental health support programs has diminished so community awareness of the support still available needs to be publicised.

Home care packages play a role in assisting elderly people to maintain good mental health through:

- Keeping them connected in their community
- Reducing loneliness – social support, home visits
- Improving health outcomes by taking them to appointments, medication management etc referrals to appropriate services
- Keeping them at home in their own environment
- Home environment checks/falls prevention
- Pastoral support by chaplains (some providers can offer)
- Case management checks and ensure people are financial entitlements eg Centrelink, mobility allowances etc. May improve a client's financial situation
- Offering evidence based programs that maintain brain health.

Anglicare delivers a range of Commonwealth funded aged care programs that support social inclusion and community participation, including the *Commonwealth Home Support Programme, Community Visitors Scheme and Commonwealth Carer Respite Centres*. The CHSP activities including Social Support Groups, Social Support Individual, Flexible Respite Individual and Centre Based Respite programs offer older people and their carers targeted support to reduce social isolation. The *Commonwealth Carer Respite Centres* also offer support to carers of older people with mental health illness, by providing respite, information and education on strategies to support the person they care for. The coordinator of the program found that when the carer was adequately

supported the older person was less likely to need specific mental health support services. With changes planned to both CHSP and CCRC funding underway, Anglicare has continued to advocate that changes must not reduce the availability of service for these clients. In the case of CHSP, Anglicare is supportive of transitional and support coordination funding/function to ensure people are transitioned effectively and safely through the aged care system.

6.5 Migrant and refugees

Anglicare welcomes the NSW Health funding investment in the delivery of trauma informed recovery oriented, culturally safe and responsive psychosocial support to refugees and asylum seekers who are experiencing mental ill health. The strength of this service is that it incorporates a multidisciplinary approach with three streams of care including a Medical Stream (psychologist), Therapeutic Stream (mental health nurses, OTs) and Community Stream (community workers, peer workers) within a community based setting. Anglicare will begin implementation of this model in Western Sydney in July 2019.

7. THE FUNDING ENVIRONMENT

7.1 Primary Health Networks

Primary Health Networks are playing an increasingly significant role in population needs-based planning and commissioning of primary health and mental health services. However, there are some limitations with this PHN structure. The structures and culture within larger metropolitan areas have not traditionally encouraged partnership, collaboration and linkages. It will take time for this culture to shift and for PHN's, Local Health Districts and community based mental health services to develop these relationships and a new way of working together. In New England, however, the PHN has engaged in good relationships with community based services. There is a strong cultural of developing partnerships for the purposes of joint tendering arrangements, including with local Aboriginal organisations.

7.2 Continuity of Support funding

Anglicare Sydney welcomes the Federal government's recent announcement to extend the Continuity of Support funding for existing PIR, PHaMS and D2DL clients to 30 June 2020 and the MH Mental Health Respite: Carer Support until 30 November 2019 to align with the implementation of the Integrated Carer Support Service. The Government must ensure there are no gaps in supports for clients of Commonwealth community mental health programs as they roll out the National Disability Insurance Scheme (NDIS) and the Integrated Carer Support Service (ICSS) for clients transitioning out of these programs.

7.3 Funding contracts

Funding contracts for regional mental health service provision need to give greater consideration to the high costs of travel, high costs of delivery in smaller regions (eg less than 500 people) where there is limited service options and stability of funding contracts. Our experience in New England and Norfolk Island indicates localised and face-to-face services are highly valued and essential in supporting people experiencing mental illness, recovery and improved engagement in local community.

Carers living in regional areas have also emphasised the need for resourcing face to face services and community capacity building activities. Good outcomes for clients are supported by the ability to employ and retain local workers representative of the region and local culture. Resourcing for

Aboriginal/CALD mental health workers through traineeships and employment opportunities can support high quality and culturally safe service delivery.

Innovation-type funds can also support the implementation of community led, community capacity building and visionary mental health service provision.

7.4 Technology

Anglicare Sydney has effectively deployed Skype Counselling and tele-health services in our Norfolk Island site, as well as part of our metropolitan Sydney services. Whilst not suitable for all clients, it has provided access to specialist mental health supports for people in our services.

While technology works for some, for others it is not so clear cut. Carers for example have reported that online platforms and services such as those provided on the Carer Gateway are no substitute for face to face service delivery. Uptake of these on-line supports will require a sustained educational and capacity building effort involving clients/carers and services alongside the delivery of localised, relational supports.

8. WORKFORCE

The sector needs workers skilled in recovery-oriented practice, not only frontline staff but practitioners working across the spectrum of healthcare. The implementation of the NDIS has also exposed the need to build capacity with the healthcare workforce to support people entering and participating in the Scheme.

Community based mental health services have an important role in supporting and retaining a skilled and supported mental health workforce. Investment in skills development, upskilling of the workforce (eg. recovery oriented, evidence based practices), a strong organisational approach to supervision and workplace practices that support mental wellbeing is required. It is the view of many Anglicare Sydney practitioners that employment of people with a lived experience is a valuable and worthwhile mental health workforce strategy, and there is growing body of research and practice principles to support and guide this approach.

For frontline community based mental health practitioners, including peer workers, there would be value in the provision of a comprehensive package of support, including coaching, regular supervision, flexible working hours, access to alternative employee assistance programs (eg persons own counsellor versus the generic employee assistance programs). An insight into the various schemes available to people with a physical disability indicates there could be more done in this area to support mental wellbeing in the workforce. Mental wellbeing initiatives also need to be extended to all staff, not only those involved in client facing work, to ensure mentally healthy workplaces.

9. PARTNERSHIPS AND COORDINATION

Service coordination between clinical and non-clinical services could be improved through:

- Increased and active involvement of Community Mental Health teams in regional and local Mental Health interagency/initiatives to improve collaborative working relationships.
- Clinical and non-clinical services prioritising collaboration activities, and where possible nominate staff that considers continuity and the ability (authority) to participate in decision making processes where relevant

- More opportunities to build relationships with key sector players (eg PHNs)
- Shared training and knowledge sharing across teams, sectors, systems
- Systems that support good information sharing between services providers, although this was deemed as challenging for our OOHC services in the context of supporting CYP with mental health. Many providers are resistant to sharing information and this is creating a barrier to supporting the child in an informed way, and is resulting in services working at cross purposes. Some services push back information requests (despite the information sharing provisions of Chapter 16A of the Care and Protection Act) and others are charging OOHC providers for release of information requests.

Case Studies in Coordination

Case Study 1: Mary has experienced mental health issues for most of her adult life, often hearing voices and leading her to feeling unsafe in her own home. Mary began sleeping rough in public toilets to escape the voices she was hearing, and eventually was detained in a mental facility located three hours away from her home town, for 6 months. Following Mary's discharge from the facility, she was put on a train and sent back home. Local services familiar with Mary, received no phone call from the facility nor were involved in any discharge planning to ensure supports were in place upon Mary's return.

Case Study 2: 'We (community-based services) often have to go out and 'find' these people, spending a lot of time engaging with them. This is a regular occurrence in regional towns' (practitioner quote).

On the other hand, Casey's experience tells a different story. Casey's discharge from a mental health facility three hour from her home town was carefully planned and involved the discharge team and community mental health teams and community based mental health provider. Upon Casey's return to her community, the community mental health team and local community based service provider built a strong relationship with Casey through regular visits and coordinated psychosocial and clinical support services. Casey has been 'well' for 3 years, living life to the best of her capacity, and engaged in the local community.

Case Study 3: The Family Mental Health Support Service worked with the local regional hospital sub-acute unit to support Lucy's voluntary stay in the unit. Arrangements were negotiated for the care of Lucy's children during their mother's stay that didn't compromise an active family law matter. Lucy was able to get the assistance she needed to manage her mental health issue whilst still managing the other life stresses that were present for her. Without this support Lucy would have refused the sub-acute unit stay with the likely outcome of continued deterioration in her mental health and ability to parent effectively.

10. PROMISING, INNOVATIVE MODELS

10.1 Step in/Step out navigation model

The current mental health system is a medical model where the client's needs are understood mainly in relation to clinical supports. It is left to individuals and families to navigate between the

different agencies to access other supports to and to resolve any service gaps or issues. For many people experiencing mental illness, it is difficult to do this because of complex and often overlapping needs e.g. financial and housing stress and vulnerabilities, such as relationship breakdown and trauma. Some have low literacy levels, or English as a second language and they may not understand entitlements, what supports are available or what they can expect from providers.

A step in/step out team model in a community based setting, would be able to work with a person intensively for the first 4 weeks (of an acute episode and/or a newly diagnosed mental illness) and is based on the evidence that if supported early, mental illnesses are less severe and of shorter duration, and are less likely to recur. The person could continue to step in/out of care as they require, and do not have to be acute to receive supports. The step in/step out 'worker' could be someone who is already known to the family, and who could work with the person (and their family) to develop a plan that is based on the individual's aspirations for their mental wellbeing, and where appropriate, involve family and other support networks.

The worker would act as the conduit between the health care and/or community based mental health service and the individual. Their influence could also extend to other life domains, such as housing, family support, employment and education to create a more structured interface between these agencies and the individual's mental health supports. This is key to ensuring interventions align to the identified goals for the individual and do not operate at cross-purposes to each other or place unrealistic expectations on the person.

10.2 Social enterprise

There is the potential for social enterprises to create a space of encounter between people with a mental illness and the broader community. For example, coffee shops, catering businesses and project based learning environments can create safe and supportive settings for interactions between services, clients and members of the public whilst supporting employment skills. The model can help to break down stigma, prejudice and the enduring assumptions about mental health in the community

11. FINAL COMMENTS

Anglicare Sydney greatly appreciates the opportunity to provide input and feedback to this Inquiry and looks forward to the final report.

Grant Millard

Chief Executive Officer