

## **Response to**

### **The Social and Economic Benefits of Improving Mental Health Productivity Commission Issues Paper**

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5 April 2019



## **Who we are**

Flourish Australia is one of Australia's leading community managed not for profit organisations supporting people with lived experience of a mental health issue to live in the community.

Language is important. We prefer to use the term lived experience of a mental health issue (or lived experience) when referring to people who access our services, instead of "mental illness". Lived experience focuses on valuing the experience people bring to the relationship they have with us, and avoids the use of otherwise stigmatising and unhelpful language that categories people unnecessarily.

Flourish Australia supports people to find and make a home, get a job and make friends and learn new things. Founded in the mid 1950s we have specialised in providing psychosocial supports and rehabilitation programs.

More recently we have begun to provide clinical services through being a lead agency in headspace Centres and delivering a primary care psychiatry liaison service building the capacity of General Practitioners and practice staff to support people with mental health issues better.

We are leading registered NDIS service provider, having commenced in the scheme in the Hunter Trial site in 2014. We currently support over 1700 people with a psychosocial disability with NDIS plans.

We are also a leading mental health organisation that focuses on employment of people with lived experience of a mental health issue – employment by ourselves<sup>1</sup> and by others. We operate the Disability Employment Services as a mental health specialist in 9 Employment Service Areas, operate Australian Disability Enterprises employing supported employees, and 54% of our staff identify as having a lived experience.

Building on our experience supporting people to get job and being an employer of around 700 people with a lived experience of mental health issue, we use our experience to assist other employers to build their capacity to create mentally healthy workplaces and opportunities for people with lived experience to sustain or gain employment. This work is led by people with lived experience.

In doing all of this, we support over 6500 people with lived experience annually (and many families and carers) across our 65 sites in Queensland, New South Wales and Victorian with outreach services into the ACT.

## **General Comment**

We welcome the Productivity Commission's Inquiry. A better understanding of the social and economic benefits of improving mental health will assist in providing better focus on this much neglected area. Fragmented and siloed services, and a large variety of funding mechanisms, work against the integrated health and social support system that would promote and sustain people's physical and mental health, improve their social inclusion and promote economic participation<sup>2</sup>.

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<sup>1</sup> Beattie, V., Meagher, J. & Farrugia, P. (2013). *Embracing inclusion: Employment of people with lived experience*. Viewed 5/4/19 at <https://www.flourishaustralia.org.au/embracing-inclusion-lived-experience>

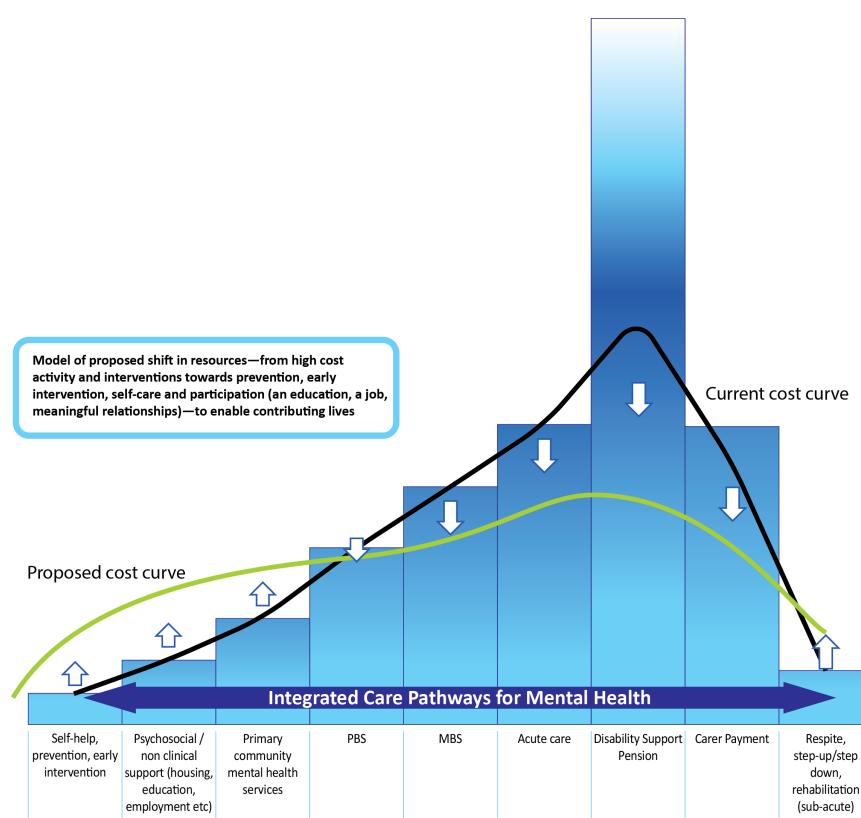
<sup>2</sup> Whiteford, H., McKeon, G., Harris, M., Diminic, S., Siskind, D. & Scheurer, R. (2014). System-level intersectoral linkages between the mental health and non-clinical support sectors: A qualitative systematic review. *Australian New Zealand Journal of Psychiatry*, 48(10), 895-906

Whilst funding for community based mental health services has increased in recent years, most notably through the NDIS supporting people with psychosocial disability arising from a mental health issue, a large proportion of mental health funding is to acute clinical services. The National Mental Health Commission (NMHC) undertook an important review which reported in 2015. It reviewed programs and services for people with mental health issues Nationally. The report made some very important recommendations.

We generally supported the National Mental Health Commission's review findings and recommendations<sup>3</sup>. Importantly, the review focussed on person centred services, integrated care pathways and argued for a rebalancing of funding. It stated:

This approach shifts groups of people towards 'upstream' services (population health, prevention, early intervention, recovery and participation) and thereby reduces 'downstream', costly services (ED presentations, acute admissions, avoidable readmissions and income support payments).

The Commission depicted the proposed shift of resources in the following graphic.



<sup>3</sup> National Mental Health Commission (2015). *Contributing Lives, Thriving Communities - Report of the National Review of Mental Health Programmes and Services*. Viewed 5/43/19 at <http://www.mentalhealthcommission.gov.au/our-reports/our-national-report-cards/2014-contributing-lives-review.aspx>

To facilitate this outcome the Commission recommended that:

7. Reallocate a minimum of \$1 billion in Commonwealth acute hospital funding in the forward estimates over the five years from 2017–18 into more community-based psychosocial, primary and community mental health services.

We agree that acute care (including inpatient hospital level care) may, at times, be needed by some people with a lived experience, however, many people we support tell us that they most need are psychosocial supports.

Our lengthy experience in supporting people in the community shows that good quality specialist community-based supports work, effectively support people to stay well and connected, and produce positive outcomes for people with lived experience, families and carers and the community. Social and economic benefits arise from integrated supports for people to stay well and in the community<sup>4,5</sup>. Our community mental health support system across its continuum, must be focussed on that outcome, delivered through integrated, evidence-based programs<sup>6</sup>, and simple and sufficient funding levels and mechanisms.

In that light, we commend to the Productivity Commission the work of Mental Health Australia and KPMG<sup>7</sup> and NSW Mental Health Co-ordinating Council<sup>8</sup> and Mental Health Victoria<sup>9</sup> who have each worked the last year to lead conversations about where investment of resources can be made to have the greatest impact.

### **Voice of people with lived experience**

Any discussion about mental health must include people with a lived experience of a mental health issue. They are experts by experience – both of mental health issues, as well as in their role as users of services. People with lived experience know what works and what doesn't. We, therefore, welcome the Productivity Commission's commitment to listening to people with lived experience as part of this Inquiry.

### **Structural weaknesses in health care**

We note the Commission's comment that "At a national level, the Australian Government has in response to the recommendations of the NMHC review, been phasing in a package of reforms" (p12). Nearly five years since the conclusion of that review, it is disappointing to see slow progress in delivering on the NMHC's recommendations that were accepted by Government.

It is of concern that a commitment to local planning and decision making, which in itself is a very appropriate consideration, has not yet addressed the unequal distribution of and access to services. A comprehensive mental health support system, with the right mix of clinical and psychosocial supports, continues to be unavailable to people who need it due to where they live.

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<sup>4</sup> Patel, V., Belkin, G.S., Chockalingam, A., Cooper, J., Saxena, S. & Unützer, J. (2013). Grand Challenges: Integrating Mental Health Services into Priority Health Care Platforms. *PLoS Medicine*, 10(5), e1001448

<sup>5</sup> Bell, T., Mendoza, J., Salvador-Carulla, L., Hopkins, J. & Alex, S. (2017). Sorting the wheat from the hay: Building integrated care for those with complex needs. *Journal of Integrated Care*, 18(S1), 1-8.

<sup>6</sup> Rodgers M, Dalton J, Harden M, Street A, Parker G, Eastwood A. (2018). Integrated care to address the physical health needs of people with severe mental illness: A mapping review of the recent evidence on barriers, facilitators and evaluations. *International Journal of Integrated Care*, 18(1), 9.

<sup>7</sup> Mental Health Australia & KPMG (2018). *Investing to save: The economic benefits for Australia of investment in mental health reform* viewed 5/4/19 at <https://mhaustralia.org/publication/investing-save-kpmg-and-mental-health-australia-report-may-2018>

<sup>8</sup> NSW Mental Health Co-ordinating Council (2018). Mental health matters: Future investment priorities for NSW viewed 5/4/19 at <http://www.mhcc.org.au/2018/12/mental-health-matters/>

<sup>9</sup> Mental Health Victoria (2018) *Saving Lives. Saving Money: The case for better investment in Victorian mental health* viewed 5/4/19 at <https://www.mhvic.org.au/policy-publications/mhv-publications>

Some argue that this inequity is the result of a continuing reliance on the medical model to plan and deliver mental health services. Advocates have for many years argued for non-medical models that take into account more than just bio-medical issues in considering what people with lived experience need to live a contributing life<sup>10</sup>. Taking medication and seeing a doctor, whilst important for many to stay well, will, however, be unlikely to support someone to participate in community or economic activity. A focus on relationships, skills building, confidence building, opportunity creation will have a much better chance of changing someone's opportunities, choices and life course. These are the types of supports and the expertise the community managed sector, organisations like Flourish Australia, bring to the sector.

We commend to the Commission the service mapping work of Professor Luis Salvador-Carulla, from the Australian National University's Centre of Mental Health Research. Professor Salvador-Carulla and colleagues have spent a number of years working particularly with PHNs mapping types of mental health services available in the community. This service mapping work clearly highlights the disparity of services, and how far we are from a comprehensive mental health support system.

The introduction of Primary Health Networks in 2015 as commissioning bodies for Commonwealth funding has provided a focus on mental health system reform, local planning and development of services to address local needs. As mentioned above, the reform and change required to provide an accessible, comprehensive, integrated and adequately funded support system is slow<sup>11</sup>. The Minister for Health's establishment of the PHN Advisory Panel on Mental Health in March 2017 was a welcome announcement, seeking to provide more consistent guidance to all PHNs across Australia. However, it is only very recently that the Report of the Advisory Panel and a guidance document around reform and system transformation has become available<sup>12</sup>.

The introduction of the NDIS is very welcome reform and we see many people who are experiencing great benefits as a result of the choice and control delivered by individualised funding. The number of participants with a psychosocial disability at full scheme will be around 64,000 compared to an estimated 650-700,000 adults with "serious and enduring mental illness" in the Australian community. There is a gap that still needs to be addressed so that people who need support (which is not NDIS or acute clinical care) can access it when required in order to participate and be part of their community. Focus needs to be maintained on effectively supporting people who fall between the NDIS and inpatient care.

### **Independent Evaluations of Programs**

As examples of our the personal and social impact of our work we note two independent evaluations of work with young people and mothers and their children.

#### **(a) Young People's Outreach Program**

The Miller Group undertook an independent evaluation of our Young People's Outreach Program (YPOP). YPOP is a recovery-focused community-based psychosocial support program designed for young people between the age of 16 and 24, who have, or are at risk of developing, ongoing mental health issues. It focuses on achieving the recovery goals identified by the young person. This may include living skills such as accommodation and

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<sup>10</sup> Wallcraft, J. & Hopper, K. (2016). The capabilities approach and the social model of mental health. In Spandler, H., Anderson, J., Sapey, B., (Eds). (2016). *Madness, distress and the politics of disablement*. Bristol: Bristol University Press

<sup>11</sup> PHN Advisory Panel on Mental Health (2018). *Report of the PHN advisory panel on mental health* viewed 5/4/19 at <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-health-advisory-panel>

<sup>12</sup> PHN Advisory Panel on Mental Health (2018). *Reform and system transformation: A five year transformation for PHNs* viewed 5/4/19 at <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-health-advisory-panel>

recreation; assistance such as income support, employment, and drug and alcohol, re-engagement with education and training, and reconnecting with family and friends.

The evaluation showed significant improvements in Life Skills Profile (LSP 39) scores indicating significant progress in life skills development. Young people reported improvements in social engagement, employment, education, independent living skills, health and wellbeing, self-esteem and confidence. They increased in participation in work or related activities as measured by the Activity and Participation Questionnaire 6 (APQ6) and time in hospital reduced by 80% over two years of participation, with significant costs savings to Government.

As a result of this program the NSW Government and its positive evaluation the NSW Government funded the Youth Community Living Support Service, which operates in a number of sites in NSW.

### **(b) Women and Children's Program**

We also engaged the Miller Group to undertake an independent evaluation of the Women and Children's program. The program supports mothers with a lived experience of mental health issue who may be homeless or at risk of homelessness, who have children who may have been removed from their care. This family focussed program seeks to build the skills and capacity of mothers to address challenges and parent their children, with a view to restoration of the family.

Up to two years post program participation, the evaluation showed 90% of mothers were living with their child/children and providing a stable home environment. All participants were in stable housing and reporting greater health and wellbeing, increased parenting skills, improved relationships with their child/children, and better management of their mental health.

At the time of evaluation just under half the Mothers entering the program had been hospitalised for significant periods, between 6 to 12 months. The evaluation showed gross cost savings to Government in avoided hospitalisation costs of \$400,000-\$500,000.

This evaluation was used by the NSW Government to establish a larger state-wide program.

### **Health workforce and informal carers**

Mental Health Peer Workers are an important and valuable addition to the mental health workforce<sup>13</sup>. Peer Work provides an opportunity for people with lived experience to use their experience of a mental health issue intentionally to support others with a lived experience. The benefits that arise are both in terms of the person receiving the support and their mental health recovery, but also the benefit of economic participation for the Peer Worker.

Flourish Australia is a National leader in the development and growth of the mental health peer workforce, employing just under 200 peer workers across our service footprint. We know the positive impact Peer Workers have on our services, the people who access them and way in which we work, because people who access our services tell us it makes a difference.

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<sup>13</sup> One of the challenges in this area, however, is a variety of definitions or peer work and how peer work is operationalised in different organisations and settings.

There is a growing body of evidence to suggest Peer Workers makes a difference to the experience of accessing services and support, as well as outcomes<sup>14</sup>. People accessing peer support have been shown to develop a stronger sense of engagement with services, activities and recovery<sup>15</sup> and to develop increased self-efficacy<sup>16</sup>. They have also reported receiving better access to primary health care, increased detection of chronic diseases<sup>17</sup> with improved physical health, mental health and quality of life<sup>18</sup>. Those accessing totally peer run services have shown improved social function compared to individuals in traditional mental health services<sup>19</sup>.

In addition, a 2013 Cochrane Review by Pitt et al concluded<sup>20</sup>:

Involving consumer-providers in mental health teams results in psychosocial, mental health symptom and service use outcomes for clients that were no better or worse than those achieved by professionals employed in similar roles, particularly for case management services.

Evidence of the economic benefits of peer work is growing. An evaluation of Mind UK's Side by Side program<sup>21</sup> concluded, cautiously, that there was an economic case for investing in "peer support initiatives". Part of that caution was due to the wide variety of actions covered by the broad concept of peer support.

Trachtenberg et al (2013)<sup>22</sup> provided an early assessment of the value of peer support in mental health care, noting small sample sizes and a limited number of studies to consider. They concluded "the financial benefits of employing peer support workers do indeed exceed the costs, in some cases by a substantial margin" (p2). They calculated a benefit to cost ration of 4.76:1 as a weighted average (p9).

In 2018, Flourish Australia and Mind Australia published a book about peer work, *Peer work in Australia: The future of mental health*<sup>23</sup>, to highlight the importance of peer work to developing and enhancing services, providing opportunities for employment - and addressing workforce shortages<sup>24</sup>. This book outlines a significant amount of evidence

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<sup>14</sup> Johnson, S., Lamb, D., Marston, L. & Osborn, D., 2018. Peer-supported self-management for people discharged from a mental health crisis team" A randomised controlled trial. *The Lancet*, 392, 409-418.

<sup>15</sup> Barber, J.A., Rosenheck, R.A., Armstrong, M. & Resnick, S.G. (2008). Monitoring the dissemination of peer support in the VA healthcare system. *Community Mental Health Journal*, 44, 433-441.

<sup>16</sup> Mahlke, C.I., Priebe, S., Heumann, K., Daubmann, A., Wegscheider, K & Bock, T. (2017). Effectiveness of one-to-one peer support for patients with severe mental illness: A randomised controlled trial. *European Psychiatry*, 42, 103-110.

<sup>17</sup> Kelly, E., Duan, L., Cohen, H., Kiger, H., Pancake, L. & Brekke, J. (2017). Integrating behavioral healthcare for individuals with serious mental illness; A randomized controlled trial of a peer navigator intervention. *Schizophrenia Research*, 182, 135-141.

<sup>18</sup> Bates, A., Kemp, V. & Isaac, M. (2008). Peer support shows promise in helping persons living with mental illness address their physical health needs. *Canadian Journal of Community Mental Health*, 27, 21-36.

<sup>19</sup> Yanos, T.P., Primavera, L.H., & Knight, E.L. (2001). Consumer-run service participation, recovery of social functioning, and the mediating role of social factors. *Psychiatric Services*, 52, 493-500.

<sup>20</sup> Pitt, V., Lowe, D., Hill, S., Prictor, M., Hetrick, S.E., Ryan, R., Berends, L. (2013). Involving adults who use mental health services as providers of mental health services to others. Accessed 5/4/19 at [https://www.cochrane.org/CD004807/COMMUN\\_involving-adults-who-use-mental-health-services-as-providers-of-mental-health-services-to-others](https://www.cochrane.org/CD004807/COMMUN_involving-adults-who-use-mental-health-services-as-providers-of-mental-health-services-to-others)

<sup>21</sup> McDaid, D. & Park, A., 2017, *Side by Side Evaluation: Economic Analysis*. London: School of Economics and Political Science viewed 5/4/19 at <https://www.mind.org.uk/about-us/our-policy-work/side-by-side/the-results/?ctald=/about-us/our-policy-work/side-by-side/slices/the-results/>

<sup>22</sup> Trachtenberg, M., Parsonage, M., Shepherd, G. & Boardman, J. 2013, *Peer support in mental health care: Is it good value for money?* London: Centre for Mental Health

<sup>23</sup> Meagher, J., Stratford, A., Jackson, F., Jayakody, E. & Fong, T. (2018). *Peer work in Australia: A new future for mental health*. Sydney: RichmondPRA and Mind Australia

<sup>24</sup> Byrne, L., Roennfeldt, H., O'Shea, P., & Macdonald, F. (2018). Taking a gamble for high rewards? Management perspectives on the value of mental health peer workers. *International Journal of Environmental Research and Mental Health*. 15, 746

supporting mental health peer work, provided by people with a lived experience of a mental health issue.

The question of the type of evidence to support peer work is an open one. Systematic reviews of peer work research to date comment on the lack of randomised controlled trials (RCTs), and as such raise questions about the impact of peer work<sup>25</sup>. Whilst there may be limited RCTs available, and as the evidence base grows, our argument is that we should continue to consider evidence broader than RCTs, and listen to and be guided by people with lived experience about what works for them.

Meagher and Naughtin argue that peer work is a ‘disruptive technology’ and comment in the first chapter of this book,

Going forward, it [peer work] will be an essential element within the suite of service offerings across the entire human service arena. Whether it be in disability, addictions, justice, parenting, education, health or mental health, it will be a stream of work that is a critically important component of one-on-one service delivery. It will be a catalyst to enable people to rebuild their lives, develop a personal sense of control, master their emotional strengths and work as models, guides and companions on people’s journeys towards a contributing life, thereby strengthening our communities” (p31).

Spurred on by our belief in the positive impact of the peer workforce, Flourish Australia currently operates two totally peer run services, one in Hervey Bay and one in Warana, both funded by the Queensland Government. These services provide individual and group-based peer support and skills development, a short-term respite retreat and a warmline to provide after-hours non-crisis support. An independent Social Return on Investment evaluation undertaken for Flourish Australia by Social Ventures Australia in our Hervey Bay service showed that for every dollar invested there was a SROI ratio of 3.27<sup>26</sup>.

### **Government funded employment support**

Flourish Australia has over 20 years’ experience in the delivery of Disability Employment Services (DES) and its previous iterations as a specialist mental health provider. Over this period the organisation has supported thousands of participants prepare for, seek and find work.

In its present form, the DES program assessment processes and Outcome measures do not adequately support certain people in disadvantaged cohorts. The rigid requirements of meeting the 13, 26 and 52 week employment Outcomes can work against people and the providers who support them due to the sometimes cyclical nature of the barriers people with lived experience face.

The current guidelines for the achievement of an Outcome require the registered jobseeker to complete consecutive weeks of employment to meet each Outcome milestone. While providers may enter a limited “permissible break”<sup>27</sup> of up to 28 days per 13 or 26 week period to extend the Outcome period, provided the person returns to the same employer and the provider enters this in a timely manner, jobseekers affected by mental health issues overall are less likely to achieve an Outcome.

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<sup>25</sup> Chien, W.T., Clifton, A.V., Zhao, S. & Lui, S. (2019). Peer support for people with schizophrenia or other serious mental illness. Cochrane Database of Systematic Reviews 2019, Issue 4. Art No. CD10880.

<sup>26</sup> Prout, K., (2017). The value of a peer operated service. *SVA Quarterly* viewed 5/4/19 at <https://www.socialventures.com.au/sva-quarterly/the-value-of-a-peer-operated-service/>

<sup>27</sup> Department of Social Services (2015), Outcome Guidelines V4.6 (p. 31)

This poses a number of issues for jobseekers and providers:

1. Jobseekers living with complex mental health issues (lived experience), particularly where these may require periodic treatments, including hospitalisation, are disadvantaged in a number of ways:
  - a) Employers are often unsympathetic to the idea of retaining an employee who requires breaks in employment. This can be for the obvious reason of maintaining the operation of the business. However, this can also be for other reasons such as the loss of Wage Subsidies, which are tied to the Outcome milestones.
  - b) Jobseekers with lived experience often have a history of not completing education, employment or other pursuits. Failure to reach an Outcome can reinforce the feelings of failure associated with incompleteness of the Outcome, particularly where a person is under Mutual Obligation.
  - c) There is no provision within the DES program for a person who has been assessed as having less than an 8 hour work benchmark. Waghorn notes that, “There are also strict rules about the minimum hours that clients must work per week (8 hours for a job to count), and rules about gaps in employment, which, if exceeded, restart the job duration clock for 13- and 26-week milestone payments. This discourages the acceptance of clients with initial goals of less than 8 hours per week, or those who may need sick leave breaks that exceed the allowable gap in employment”<sup>28</sup>. This acts as a further disincentive for potential jobseekers even beginning the journey to employment, or finding supports for employment that is less than 8 hours per week but that could contribute significantly to a person’s recovery from mental health issues.<sup>29</sup>
2. Similarly, providers supporting jobseekers affected by mental health issues are disadvantaged in a number of ways:
  - a) As the majority of funding is connected to the achievement of an Outcome, providers supporting people with mental health issues are likely to receive less funding due to periods of inactivity of the people they support. For instance, a provider is no longer eligible to collect quarterly Service Fees for person who has been placed into employment. If the person does not achieve the Outcome due to their mental health issues, the provider remains unfunded for often long periods.

**Example:**

A jobseeker achieves a 13 week Outcome with an employer but due to their mental health issue requires a five week break at week 20 of employment prior to the 26 week Outcome.

The employer is supportive and the person returns to work after the five weeks and continues on in employment.

In this case the provider does not receive payment for the 26 week Outcome and must “re-anchor” the placement to reset the

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<sup>28</sup> Waghorn, G. (2013). *Severe mental illness and work*, ANZJP Correspondence. *Australian & New Zealand Journal of Psychiatry*, 47(5).

<sup>29</sup> Waghorn, G. (2013). *Ibid*

employment clock after the person returns to work. This means the provider must support the person to achieve a second 13 week Outcome, which is non-paid (13 week zero dollar Outcome) and the 26 week Outcome before another payment may be achieved. This example results in the provider remaining unpaid for support for at least 39 weeks while offering often weekly supports.

- b) Compounding this for specialist mental health providers is the assessment process for the assigning of funding levels, benchmark employment hours and the deemed level of impairment assessed during the Employment Services Assessment (ESAt). This assessment process influences a number of key factors used in applying the regression calculations to provider performance including the likelihood of the provider's jobseeker caseload in achieving an Outcome. Disability Employment Australia, the Peak Body for DES providers states, "Work needs to be done to improve the utility, reliability and validity of assessments. Regression factors consider the primary disability, but also the service requirements, higher-end needs and labour market conditions. The ESAt/JCA is the source of much of this data – the validity of the ESAt/JCA data to allow for accurate regression is questioned by the industry"<sup>30</sup>.
- c) The Star Rating of provider performance as a result of the ESAt and regressions calculations reflects not only provider performance but for underperforming providers as measured by the scale, the potential loss of business due to reallocation. An OECD report noted, "Providers specialised in youth at risk, mental health, and homeless or at risk of homelessness, have on average relatively low Star Ratings. This seems to also be true for providers at remote sites and some depressed metropolitan areas. Research should investigate possible technical reasons why the Star Rating regressions over-predict expected outcomes for certain disadvantaged client groups"<sup>31</sup>.

During the 2013 DES DMS reallocation process, Disability Employment Australia noted that "22.9% of all DMS contracts were in scope. During this reallocation round, specialist mental health (46%) and psychiatric disability (43%) contracts are twice more likely to be in scope for reallocation than generalist contracts (19%)."<sup>32</sup> The charts below from Disability Employment Australia's 2013 Report show the business reallocation "in scope" contract comparisons and Star Rating of mental health specialist providers as measured against generalists providers.

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<sup>30</sup> Disability Employment Australia (2013). *DMS Reallocation and Specialist Mental Health and Psychiatric Disability Contracts*

<sup>31</sup> OECD (2012). *Activating Jobseekers: How Australia Does It*. OECD Publishing. <http://dx.doi.org/10.1787/9789264185920-en>

<sup>32</sup> Disability Employment Australia (2013), *DMS Reallocation and Specialist Mental Health and Psychiatric Disability Contracts*

Chart 1: DES-DMS Star Ratings Contract Level September 2013, by select specialist type

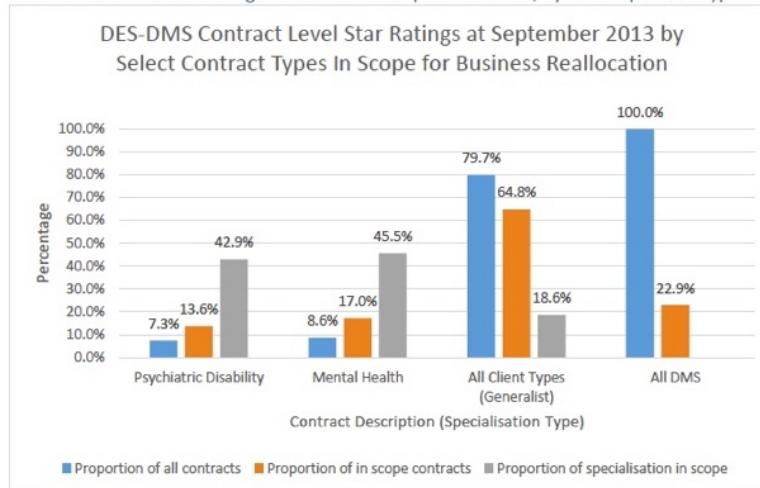
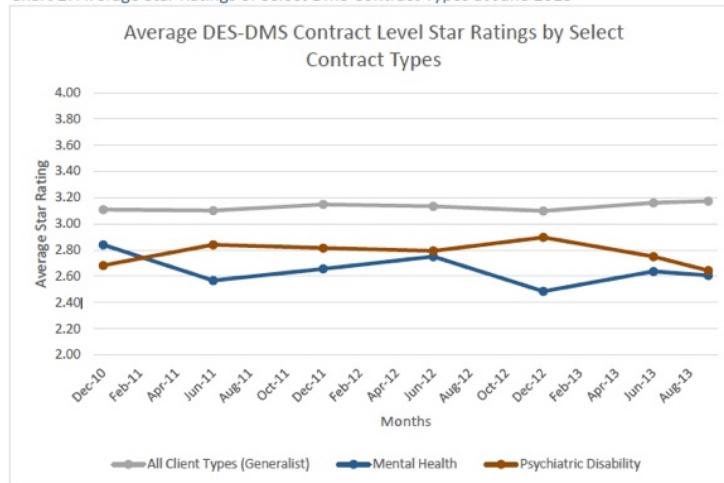


Chart 2: Average Star Ratings of Select DMS Contract Types at June 2013



This suggests that jobseekers with lived experience may be disadvantaged when engaging with the DES program. In additional mental health specialist DES providers, who are arguably most suited to supporting this cohort, are financially disadvantaged and are more likely to lose contracts as a result. The financial disadvantage and possible threat of business loss may result in less resources being available to jobseekers accessing mental health providers and that those providers may be less able to invest in future supports.

As around one third of people accessing the DES program have a psychosocial issue listed as their primary disability, further review of the program may be required to better support people with mental health issues. This review could include:

- 1) Reassessing the weightings of the ESAt and regression analysis for people with mental health issues.
- 2) Allowing more flexibility for mental health supports in regards funding levels, breaks in employment and Outcomes to enable providers to continue support during a cyclical mental health issue.

- 3) Inclusion of supports for people with benchmark employment hours of less than 8 hours to make it easier for people with long term mental health issues to approach open employment.

### **Overseas approaches**

Our Acting General Manager, Employment undertook a study tour last year to look at other models of employment support in Europe to see if we could identify any ways in which our own organisational focus on employment could be enhanced. He found that other jurisdictions, such as those in Western Europe, approach the funding of disability employment placement in general on a different model. Generally speaking, participants and employers receive greater financial support to provide training and wage supplementation. These supports are often much longer in duration than currently available through DES and Job Active.

### **Wage Subsidies and Supported Wage Systems**

Across Western Europe, minimum wages are usually applied to people working in job placements even when a supported wage is indicated via an approved wage assessment tool.

For example, The Netherlands ensures that employers are expected to pay “supported employees” at least the minimum wage and are reimbursed the difference between the assessed supported wage based on capacity and productivity and minimum wage through local governments. These arrangements are of long duration based on minimum requirements and have successfully supported participation in the workforce for those who would otherwise be distanced from employment. The current laws are based on “loonkosten subsidie” or *wage cost subsidy*<sup>33</sup>.

In Sweden, similar laws apply. Samhall is a large semi-government organisation that supports 25,000 disability employment placements at over 13,000 organisations across Sweden<sup>34</sup>. The same principles of minimum wages and job matching apply there.

A recent initiative in the Netherlands is the mandated quota system for government and business organisations to employ people with a disability, including mental health issues. This aims at creating 125,000 extra jobs for disadvantaged people via an agreement and quota system<sup>35</sup>. For comparison with Australia, the Netherlands has a population of 17m and a high minimum wage approximating \$15AUD per hour.

Another Dutch initiative has been the signing of an Accord, *Working Together on What Works*, specifically agreed to develop better ways of supporting people experiencing mental health issues in sustainable employment. Significantly the Accord was signed by Peak Bodies representing hundreds of non-government support agencies, government institutions such as the UWV and GGZ (Mental Health Care Department) and the Union of Local Governments who have responsibility for much of the country’s employment services delivery. The Accord is valid from 24 May 2018 to 1 June 2021 and was signed in the presence of the State Secretary of Health<sup>36</sup>.

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<sup>33</sup> See: <https://www.divosa.nl/onderwerpen/loonkostensubsidie>

<sup>34</sup> See: <https://samhall.se/in-english/>

<sup>35</sup> See: <https://www.rijksoverheid.nl/onderwerpen/werken-met arbeidsbeperking/meer-banen-mensen-arbeidsbeperking> (Dutch Government website)

<sup>36</sup> The Accord can be accessed (in Dutch) at: [Convenant\\_Samen\\_werken\\_aan\\_wat\\_werkt](https://convenant-samen-werken-aan-wat-werkt)

Key points from the Accord are:

- Developing greater recognition of the plight of mental health issues in the workplace to prevent people falling out of paid work into uitkeringen (benefits and pensions). It also aims at attracting people into the workforce.
- The sharing of successful practice and knowledge and the further development of these.
- Financial support made available to organisation that promote the de-stigmatization of mental health issues with aim of encouraging other organisations to do the same.
- Support for employers to engage people with mental health issues in employment
- The active contribution and safeguarding of partnerships between the key government and non-government stakeholders
- Promote guidance regarding sustainable work for people with mental health issues through the training of professionals working in the employment, education, clinical and care sectors.

### **Mentally healthy workplaces**

Recognising the growing need for support for employers in creating and sustaining mentally healthy workplaces and providing people managers and others with knowledge and skills, Flourish Australia began providing training and consulting services in 2014. Importantly, we have people with lived experience of a mental health issue deliver this work.

To date we have worked with a wide variety of employers including in the Government, Engineering, Transport, Sport and Community Services sectors. It is pleasing to see employers from such a wide range of sectors identifying the importance of mental health in the workplace and actively seeking to address the issues that arise – for the benefit of employees and the organisation.

Our work in this area has been heavily influenced by the work of the Mental Health Commission of Canada<sup>37</sup> as well as our own experience as an employer of around 700 people with a lived experience.

Employers approach us because they want to support their employees better in order to create positive workplaces and to deliver the product or service the organisation exists to deliver. In our experience, foundational information and education about mental health issues, their prevalence, people's support needs and addressing stigma is a starting point. As such, much our work has included specific training for all staff (including people managers) raising awareness of mental health in the workplace. We also focus on how managers can raise issues confidently and respectfully, and develop flexible solutions with people. In addition, we discuss how people can look after their own mental health and how they can appropriately support work colleagues.

It is notable that the importance of reasonable adjustment and flexibility in workplaces around mental health issues is under recognised. Often, turning conversations from performance issues to understanding and addressing the underlying factors makes a significant difference to possible outcomes, and the experience of everyone involved. Supports for managers, leaders and HR staff to respond positively and effectively to people who may be experiencing a mental health issue are therefore essential.

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<sup>37</sup> Mental Health Commission of Canada, *Workplace* accessed 5/4/19 at <https://www.mentalhealthcommission.ca/English/what-we-do/workplace>

## Funding arrangements

Based on our experience in providing community-based supports to people with lived experience and our commitment to mental health peer work we have also developed the Resolve Program, funded by Australia's first Social Benefit Bond in the mental health sector<sup>38</sup>.

The Bond is an innovative funding mechanism bringing together Government funding and private investor capital. Social Ventures Australia commented as part of the capital raising:

The Resolve SBB is expected to improve the mental health and wellbeing of participants, while generating significant savings for the NSW Government through a reduction in participants' utilisation of health and other services, in particular by reducing the number of days spent in hospital. These savings will be shared with Flourish, to fund the delivery of the Resolve Program, and with investors to provide a financial return on their capital<sup>39</sup>.

The program is a partnership between the NSW Government, Flourish Australia and Social Ventures Australia. The program is targeted at keeping people well and in the community. The Resolve Program is delivered by Peer Workers and supports people who have been in hospital for between 40 and 270 days in the last twelve months due to their mental health issue. The Annual Investor Report for the first year of operations<sup>40</sup> was released in March 2019.

The program has been established with a propensity score matched counterfactual/control group to measure differences due to the Resolve Program, and an independent evaluation is being undertaken. Initial results are positive, though a small sample size and year one being an establishment year suggests caution in interpretation.

In terms of outcomes achieved:

Outcome measure	Reduction relative to Control Group
National Weighted Average Units (NWAUs)	12%
Hospital admissions	35%
Hospital bed days	9%
Emergency department visits	20%

## Conclusion

We support over 6500 people with a lived experience each year. Every day we see positive outcomes from investment in people and support to pursue a contributing life.

People with lived experience want to participate in the social and economic life of the community. Our experience shows us that they can, and be successful. They just need the right supports and opportunities.

We hope this Inquiry will help guide the way to a better future.

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<sup>38</sup> Social Ventures Australia (2018) *Resolve SBB* accessed 5/4/19 at <https://www.socialventures.com.au/work/resolve-sbb/>

<sup>39</sup> Social Ventures Australia (2018) *Resolve SBB* accessed 5/4/19 at <https://www.socialventures.com.au/work/resolve-sbb/>

<sup>40</sup> Social Ventures Australia (2019). *Resolve Social Benefit Bond Annual Investor Report Period ending 30 September 2018* accessed 5/4/19 at [https://www.socialventures.com.au/assets/Resolve\\_SBB\\_Annual\\_Investor\\_Report\\_2019\\_web.pdf](https://www.socialventures.com.au/assets/Resolve_SBB_Annual_Investor_Report_2019_web.pdf)