

Response to the  
Productivity Commission  
Inquiry into Mental Health  
Draft Report



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## Executive Summary

One Door Mental Health supports the general direction of the Productivity Commission Inquiry into Mental Health Draft Report, released in October 2019. This response addresses the information requests sought by the Commission, as well as makes comment on recommendations made in the Draft Report. These responses have been provided in the order they are covered in the Draft Report. In addition to our initial submission, we believe this response will provide further clarity and weight to our own recommendations and will ensure better outcomes for all people with mental health issues and psychosocial disability.

One Door supports reinstating flexible block funding for a range of mental health-related programs. One Door is unhappy that several programs, such as Partners in Recovery, Personal Helpers and Mentors, and Day to Day Living have been phased out to support the NDIS. We advocate for the continuation of these programs, or similar programs, for people with complex and severe mental illness.

In particular, One Door advocates for the ongoing status of centre-based models for people with severe mental illness. Support Facilitators in centre-based services can provide the “care coordination” mentioned in the Report. One Door uses a range of centre-based models that respond to the expressed needs of people who access our services. Evaluation of one model of our centre-based services, the Clubhouse model, is explored.

One Door would like to see the continuation of the headspace program around Australia. Funding for headspace will activate the best outcomes if it was independent of Primary Health Network (PHN) policy restrictions, enabling young people with all mental health support needs to access holistic services through a “no wrong door” approach.

One Door would also like to see the expansion of the peer workforce in the mental health sector; in particular, One Door would like to see peer workers embedded within mental health teams, engaging in more than a tokenistic manner. The Community Managed sector is leading in the engagement of peer workers.

One Door has strong feedback on the NDIS. This includes, but is not limited to: understanding why eligible people with psychosocial disability are not joining the NDIS; providing ongoing and adequate services for the large number of people with severe mental illness ineligible for the scheme; increasing cost estimations from the NDIA to adequately fund service quality, office costs, accreditation and overheads –for example, a rise of 10% for level 3 DSWs is justifiable. People with episodic mental illness should be able to come in and out of service, as dictated by the nature of their recovery. One Door’s experience suggests that there are a significant number of people working with the NDIS who have inadequate understanding of psychosocial disability. One Door supports a collaborative, planned and urgent support around psychosocial disability with the NDIA and Local Area Coordinators.

Pricing and cost options for psychosocial disability need to be improved; however, frequent Price Guide changes have affected the viability of service provision organisation.

One Door recognises the challenges for young carers of someone with mental illness and advocates support for this cohort. One Door would particularly like to see the continuation and expansion of funding for its On Fire respite programs to meet the unique needs of young carers aged 8-17.

Employment support for people with mental illness is a priority area. One Door advocates for Newstart to create more incentives for work for people with mental health concerns. In addition to the New Employment Services program, One Door recommends the continuation of the Transitional Employment Program which involves participants being offered paid job placement with a local employer for 6 months to develop employability skills including self-confidence, reliability, teamwork and job specific skills.

One Door supports the use of online mental health supports for Culturally and Linguistically Diverse groups. In particular, this kind of intervention may help people with low intensity or mild conditions. One Door has worked productively with Settlement Services International to this end. However, One Door also recognises that some people may suffer disadvantage compromising their use of online mental health supports, such as those with low literacy, lack of access in rural and remote areas, and /or being in a financial position where online devices are out of reach.

One Door generally supports the rollout of low intensity therapy coaches, however, remains critical of the use of K10 as a tool to stream participants. The approach could be delivered by phone; an approach that could avoid the stigma of seeing a mental health professional or could help reach rural and regional need. One Door is keenly aware of the paucity of affordable psychiatrists for people with living with mental health issues.

One Door is acutely aware of the scarcity of bulk-billing psychiatrists, arguing that Australia has a two-tiered (private versus public) mental health system. This is an issue in both metropolitan and regional areas. One Door advocates a range of incentives or penalties to increase the level of public psychiatry. In many cases, a GP may be able to manage a patient who may otherwise need to see a psychiatrist, for example for repeat prescription of medication

One Door would like to see the better treatment of forensic patients. However, there is a lack of data relating to recidivism of forensic patients receiving mental health support versus those who did not. One Door recommends further investigation into this issue.

Housing First is an essential policy. It gives stability for people with mental illness to receive support relating to ongoing tenancy, anti-social behaviour, temporary absences and information sharing. This approach prevents eviction of people with mental illness.

Support for police to better understand and engage with people with mental illness is critical. One Door has been successfully working with the Mental Health Intervention Team who provide education and engagement within NSW Police. This training assists officers when dealing with people with a mental health issue. This program is also aimed at improving mental health awareness and wellbeing in the workforce.

One Door agrees with the Report recommendation to place Wellbeing Leaders in schools, and notes that many Community Managed Organisations (CMOs) are well-placed to provide this service.

Good mental health data is vital for service delivery. All levels of government need to routinely, and in a timely manner, return synthesised or analysed data to the CMO sector.

One Door is sceptical about concept of a regional funding pool. One Door does not believe that the PHNs currently have the knowledge or skills to manage this proposal. Unless significant changes are made to the whole scheme, this proposal would not work; it is not capped, it is not demand-driven and psychologists charge co-payments. One Door recommends a thorough evaluation of the scheme and its effectiveness prior to any change.

One Door supports the Rebuild option for the Mental Health System. The principle of a single government plan of action and coordinated implementation is sound. Despite possible barriers, the proposed oversight of all mental health funding and commissioning provides hope for consistency and increased system-capacity. If, under this proposal, Regional Commissioning Authorities (RCAs) genuinely had control of all mental health funding in region, we could achieve significant change in how services are delivered, for example, re-directing funds from inpatient to community care models.

## About One Door Mental Health

One Door Mental Health (formerly the Schizophrenia Fellowship of NSW) is a specialist mental health recovery organisation with a 33 year history, committed to improving access to services and the circumstances of people living with severe and complex mental illness. One Door currently delivers trauma-informed and recovery-oriented support through the NDIS for people with psychosocial disability.

One Door provides psychosocial community mental health programs, care coordination, housing, clinical and peer supported services. One Door has delivered services and coordinated community psychosocial care for people across silos of sectors, funding and policy. We have achieved this through building relationships and trust with other providers, funding bodies and most importantly, individuals and the communities in which they live. We are committed to supporting carers and provide clinical services such as headspace, Health Care and You In Mind.

The experience One Door has in delivering this support for people with mental illness, as well as One Door's extensive experience in the psychosocial disability sector, position us well to comment on the Australian mental health system.



## Draft Recommendation 5.3 - Headspace

One Door wishes to respond to Recommendation 5.3, which address the ongoing nature of the headspace program. We support the existing model and framework for headspace services. headspace has been providing effective services to young people, and the reduced stigma branding of headspace has increased the number of young people accessing mental health services.

One Door does not agree that funding for headspace should be conditional on centres being instructed to deliver solely low-intensity services -headspace was developed to offer a “no wrong door” for young people and should continue with this platform. Young people are drawn to the recognisable headspace brand, regardless of the level of intensity of their mental health needs. Young people actively seeking support from headspace demands celebration and encouragement, not an on-referral to another service because of rigid policy and targets. Currently, headspace is over-managed by both headspace National Office (hNO) and PHNs. Their roles overlap, leading to duplicate reporting, and sometimes conflicting messages. This creates confusion for sites on the ground. PHNs now control the money, but they may not always understand the model, and/or may make funding decisions that compromise the model. One Door favours a return to hNO having control of the funds.

The funding model must be reviewed; it is not responsive to increases in demand and changing demographics. headspace centres should be proportionately funded based on population figures of the area or region they are servicing, and with a scale of per-person funds according to their intensity of support requirements. Young people who experience severe mental illness must be eligible for support, with associated funding provided to headspace. Consultant psychiatry should also be funded, so that all supports are under one roof.

## Information Request 5.1 - Low Intensity Therapy Coaches

This approach is currently being rolled out by PHNs: to stream people with a low K10 score into CBT coaching. The approach has evidence-based merit, however, over reliance on a poor tool like K10 to stream people impacts the reliability of this approach to target the right group. In this rollout, the PHN reduced One Door’s hours of service (and therefore funding) to provide face to face psychologists to support people; in favour of using the funds to stream people into this type of service. In metropolitan areas, this appears to be counterproductive. However, in rural and remote areas, where there is a serious shortage of psychological services practitioners, this approach could be delivered by phone. It could also support people who are hard to reach due to the stigma of accessing services in person. This approach must be supported by capacity to step-up care for those where this approach not suitable, or where their needs change.

## Information Request 6.1 - Online Supports for Culturally and Linguistically Diverse Peoples

Most online tools are only in English, with an emphasis on western concepts of mental health. This approach excludes people based on both language and culture. One Door endorses the urgent and critical requirement for this to change. We ensure that our materials are translated into key community languages, and we partner with specialised organisations in the delivery of supports.

One Door has worked extensively with Settlement Services International (SSI). In partnership with beyondblue, SSI worked closely with people from culturally and linguistically diverse communities to develop The New Roots Project. This is a free smart phone app (for iPhone and Android) that builds the health and wellbeing of men, aged 18-45, from Arabic, Farsi and Tamil-speaking backgrounds, who have recently arrived in Australia, and to help them overcome the daily challenges as they start a new life.<sup>1</sup>

We are aware that people who are most disadvantaged (for example, refugees) have limited English but also are often illiterate in their own language and English. Women are more likely to be illiterate than men, although refugee women are more likely to access psychological treatment than refugee men. SSI considered this in focusing their online trial 'Tell Your Story' (TYS) for refugee men. YYS consists of 11 short, interactive web-based modules that contain information, short videos, and activities. Arabic, Farsi and Tamil-speaking men shared their personal experiences overcoming stigma and describing how they successfully sought support for PTSD. Participants completed up to 3 modules per week over a 4-week period<sup>2</sup>

Additionally, people who are refugees may: lack of access to affordable devices and internet services; experience conflict in seeking support outside the family (online or in person); and young people may experience stigma in accessing information in their first language.

Online support could also be effective in supporting people with low intensity (mild) conditions that respond to information and changes in thoughts and attitudes, for example through a Cognitive Behaviour Therapy (CBT) approach. While it may be difficult to measure the effectiveness, studies have demonstrated outcomes and improvements with mainstream groups. All trials should be informed by data to focus on supporting people who speak the fastest growing languages such as Arabic, Chinese, African languages.

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<sup>1</sup> Settlement Services International, (2019). Online at <https://www.ssi.org.au/48-news/ssi-news-blog/565-new-roots-using-smartphones-to-help-refugee-men-in-australia>. Accessed 20/1/2020

<sup>2</sup> Ibid. <https://www.ssi.org.au/news/media-releases/1557-online-program-helps-traumatised-refugees-overcome-mental-health-stigma>. Accessed 20/1/2020

## Draft Recommendation 11.2, Information Request 7.1 - Access to Psychiatrists

One Doors resoundingly supports the concept proposed in recommendation 11.2. We recognise that Australia has a two tier mental health system: one for people who have private health insurance and the means to afford huge out of pocket co-payments for psychiatric appointments; and one for everyone else (the majority) who rely on the poorly funded public system with long wait lists.

One Door recognises that there is no easy solution, given the two tier mental health system; general lack of psychiatrists in the Sydney area, complete dearth of psychiatrists in the regions; and the prohibitive cost of private psychiatrists.

One Door recommends the following:

1. Ongoing funds for private psychiatrists to provide support for those who cannot afford visits, who are often the people who need them most, and/or
2. Medicare incentives or penalties for psychiatrists to see a certain percentage of bulk billed clients. This would not be a popular policy, however, currently there is no incentive for a psychiatrist to bulk bill other than their own good will to do so.
3. Ongoing funds for a Clozapine clinic. Currently private or bulk-billing psychiatrists can only spend a few minutes with patients, and there is not adequate time or money for longer, needed assessments.
4. Ongoing funds to build on the capacity of PHNs to fund consultant psychiatrists; this is still a scarce resource. For example, there are only one or two bulk billing psychiatrists in the whole of South and South Western Sydney, so people wait for public health (LHD) or PHN funded services.
5. Ongoing funds for consultancy services to GPs who can access advice regarding medication and continue to provide the primary care.

## Draft Recommendation 11.4 - Strengthen the Peer Workforce

One Door believes that there is a need to promote and embed a peer workforce in mental health services; in particular, it should be embedded in government mental health services in a manner which is not tokenistic. There is evidence that peers can draw on their own experiences of mental ill-health and navigating the mental health and allied systems, to help consumers with mental health issues. With that said, employing a peer workforce requires employers to have a degree of flexibility and responsiveness that is different for non-peer employees. The CMO sector is enhanced through the engagement of a peer workforce.

## Draft Recommendation 10.4 – Psychosocial Supports and Care Coordination

The advent of the National Disability Insurance Scheme (NDIS) has seen a large amount of money moved from centre-based mental health services into the NDIS. This has unfortunately meant that several centre-based services that provided quality support to people with mental illness – and, in particular, people with severe mental illness – are no longer available. The NDIS is not an effective replacement for psychosocial support programs.

Increasingly PHNs and State governments fund very narrowly defined programs, with specificity in relation to the target group, the supports that can be offered, or the length of time the service can be offered. Integrated holistic ‘rehabilitation’ to support mental health recovery is rare. Positive consumer outcomes are achieved from holistic supports that include physical health, mental health, social activities and assistance to return to work.

One Door calls for flexible block-funding for centre-based services to be reinstated and directed to evidence-informed models of delivery. We believe that the International Clubhouse model could have measurable benefits on the mental wellbeing of people with severe mental illness. The International Clubhouse model offers supported work placements to assist people to return to work. For example, One Door’s Pioneer Clubhouse is a community mental health service model for psychosocial rehabilitation, that helps people with a history of serious mental illness re-join society and maintain their place in it. The model builds on people's strengths and provides mutual support, along with professional staff support, for people to receive prevocational work training, educational opportunities, and social support. Its validity is moderated and approved by the International Center for Clubhouse Development<sup>3</sup>. There is a strong body of research supporting the effectiveness of the Clubhouse model<sup>4</sup>.

Under the NDIS, One Door proposes an Alternative Commissioning model for centre based supports. This requires up-front payments to cover infrastructure costs for centre-based supports, where government assists NDIS Thin Markets by sharing the demand risk. There is an example of government doing this in the Out Of Home Care (OOHC) sector, where the funding allocation follows the child/young person, but government also funds a house for children/young people with high/complex needs.

Furthermore, One Door would like to see the reinstatement of the Partners in Recovery (PIR) program. PIR gave a spectrum of care to people with severe mental illness, in an accessible

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<sup>3</sup> McKay, Colleen; Nugent, Katie L.; Johnsen, Matthew; Eaton, William W.; Lidz, Charles W. (31 August 2016). "A Systematic Review of Evidence for the Clubhouse Model of Psychosocial Rehabilitation". *Administration and Policy in Mental Health and Mental Health Services Research*. 45 (1): 28–47

<sup>4</sup> Clubhouse International, (2019). Online at <https://clubhouse-intl.org/resources/articles-library/>. Accessed 13/1/2020

and supportive environment. PIR successfully matched consumers with Support Facilitators. A Support Facilitator then linked consumers to a range of services, including GP and psychiatric services, housing services, employment training and placement, housing and tenancy support and justice/forensic support. The Support Facilitator neatly fits the description of “care coordinator” given in the Commission’s Draft Report.

## Draft Recommendations 12.1, 12.2 and 12.3 – Psychosocial Disability and the NDIS

It has been estimated that 64,000 people with psychosocial disability are, or would be, eligible for the scheme. However, take-up of NDIS packages by people with psychosocial disability has been lower than this number. Data collected since August 2018 shows a high proportion of people (27-28%) have been deemed ineligible for the NDIS, and that many of the high proportion (about one fifth) of people who are not applying for the NDIS have the highest support needs<sup>5</sup>. Challenges that prevent individuals from engaging with the NDIS include: the stigma of identifying as living with a disability, lack of information or lack of ability negotiate NDIS processes, cost of gaining expert evidence and client fluctuating mental health. Additionally, NDIA assessment staff have a serious deficiency in knowledge of psychosocial disability and fail to achieve adequacy or consistency in planning for the support needs of people with psychosocial disability<sup>6</sup>. The sector acknowledges that the NDIA has attempted to roll-out measures for their staff to increase their capacity, however it is a slow process. One Door has already provided training sessions for local NDIA and Local Area Coordination staff. We welcome a collaborative, planned and urgent approach with the Agency and LACs to buddy, or otherwise impart, our knowledge and expertise in providing meaningful and responsive support to people with psychosocial disability.

The Mental Illness Fellowship of Australia (MIFA) has estimated that there are about 225,000 people with severe mental illness in Australia who are not eligible for the scheme, but still need support. MIFA has been calling for a yearly sum of \$500 million to provide services to this cohort. This includes approximately 50% of people who were previously supported by the PIR, PHAMs and D2DL funded programs.<sup>7</sup>

There is an urgent need to improve pricing and options for mental illness. The cost model for Disability Support Workers under the NDIS is insufficient. There is grossly inadequate funding provided for office costs, service quality, accreditation and genuine overheads. The

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<sup>5</sup> Hancock, N., Gye, B., Digolis, C., Smith-Merry, J., Borilovic, J. & De Vries, J. (2019). Commonwealth Mental Health Programs Monitoring Project: Tracking transitions of people from PIR, PHAMs and D2DL into the NDIS. Final report. The University of Sydney & Community Mental Health Australia, Sydney: 1-2

<sup>6</sup> Ibid: 23

<sup>7</sup> Hancock, N., Gye, B., Digolis, C., Smith-Merry, J., Borilovic, J. & De Vries, J. (2019). Op cit: 3

community sector has been subsidising provision of NDIS service to the value of millions of dollars. The outcome of this insufficiency is that people eligible for the NDIS are not receiving the quality of support they need, and some service providers are “going under”.

One Door urgently seeks to meet with the Commission to discuss an interim price rise or loading to reduce the burden of our losses in providing supports this year. There are several areas that need attention. We believe the following is easily justifiable:

- a price increase for high intensity support of at least 10% for Level 3 DSWs<sup>8</sup>
- increased, and flexible application of, provisions for transport with participants. The aim of the scheme is to help people achieve a meaningful life, for example, participants who volunteer but live in regional areas cannot get transport to their volunteer positions. It is counterproductive for the NDIS to promote the scheme as wanting/expecting people to achieve and recover, but to then exclude all the necessary elements in NDIS plans for participants to achieve and recover.

The NDIS has implemented 4 Price Guide changes (1<sup>st</sup> Feb, 1<sup>st</sup> July , 1<sup>st</sup> October and 1<sup>st</sup> December 2019) in a 12 month period. This has a severe impact on the viability and sustainability of organisations. Every Price Guide change triggers the need to update Service Agreements, which distresses consumers and interrupts the flow of their supports. It also increases an organisation’s administrative burden, which is not covered by the ‘loading’ in a Price Guide that is designed to develop (surely a single) Service Agreement. Organisations position themselves to be sustainable, in alignment with the Price Guide. The Price Guide then changes, and the organisation is forced to rethink their business model. This is an unreasonable and untenable expectation and must be addressed. One Door asks the Commission to review this concern and align it with their own recommendations relating to block funding, certainty and timeframes.

The episodic nature of many mental illnesses demands a specialised response. One Door supports a reform to the NDIS to let people with psychosocial disability come in and out of service as dictated by the nature of their recovery; with supports scaled up and down according to their need, and without penalty against their NDIS plan based on utilisation.

One Door draws attention again to the ongoing support needs of people who accessed PHAMS, PIR, Day2Day Living - those programs that were shut down to pay for the NDIS. Transition funding to June 2020, provided to the PHNs and commissioned from the CMO sector, is in place to support ex-program participants to access the NDIS. Those consumers who receive transition support face the same barriers that we have previously described.

On 1 July 2020, it is very likely that consumers and providers will still be working hard to find a solution to the barriers, and that significant numbers of people who we have been

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<sup>8</sup> One Door (2019). Correspondence from Andrew Young to the NDIA.

supporting will not have a definite status on their NDIS eligibility. Continuity of Support (COS) funding (for ex-program participants who are ineligible for the NDIS) has been inconsistently rolled out through multiple PHNs, with varied interpretations of the scant guidelines. The National Psychosocial Services (NPS) funds are wholly inadequate for the sheer volume of people who have significant mental health support needs. Collectively, these measures have decimated and further segmented the mental health sector, and caused unwarranted confusion for consumers, carers, communities and providers. One Door is available to meet with the Commission to discuss alternate approaches that could bring clarity and cohesiveness in the packaging, intention and rollout of future funds.

### Draft Recommendation 13.3 – Family-Focused and Carer-Inclusive Practice - Young Carers

One Door was disappointed to note that young carers who are caring for a family member with a mental illness were not mentioned in the Draft Report. The Australian Bureau of Statistics<sup>9</sup> has found that there were 119,800 young carer households (households with at least one carer aged 15-24 years) in 2016, representing 1.4% of all households in Australia. Young carer households were more likely to be single parent families (26%) than households with young people who were not carers (20%).

Young carers of people with mental illness are more likely to develop mental health and/or psychosocial problems. Compared with other children, they are at greater risk of disrupted attachments, academic and peer interaction problems, poorer school attendance, and behavioural and emotional problems. Stigma, burden and stress are common<sup>10</sup>. An early intervention and support approach could circumvent some of these negative outcomes.

In response to this problem, One Door Mental Health set up an evidence-informed program, On Fire, which provides on-site and residential supports for children caring for someone with a mental illness. The goal is to increase hope, resilience and wellbeing for these children. An academic appraisal of On Fire found significant improvements for On Fire participants<sup>11</sup>. These improvements included children reporting an increase in total hope (conceived as the sum of 'agency', the ability to initiate and sustain goal—directed action, and 'pathways',

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<sup>9</sup> Australian Bureau of Statistics (2016). *Young Carers*. Online at <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Young%20Carers~143>. Accessed 13/1/2020.

<sup>10</sup> Mowbray, C.T., Bybee, D., Oyserman, D., Allen-Meares, P., MacFarlane, P. and Hart-Johnson, T., 2004. Diversity of outcomes among adolescent children of mothers with mental illness. *Journal of emotional and behavioral disorders*, 12(4), pp.206-221. Maybery, D., Steer, S., Reupert, A. and Goodyear, M., 2009. The kids coping scale. *Stress and Health: Journal of the International Society for the Investigation of Stress*, 25(1), pp.31-40.

<sup>11</sup> Foster, K., McPhee, I., Fethney, J. and McCloughen, A., 2016. Outcomes of the ON FIRE peer support programme for children and adolescents in families with mental health problems. *Child & Family Social Work*, 21(3), pp.295-306.

ability to find means to achieve goals). The report found a significant increase in positive connections outside the family for participants after 4 months in On Fire. It also found that further support for achievement of program goals, specifically social belonging and development of social capital.

One Door has sourced funding for the On Fire program since 2001. Recent Commonwealth changes to implement the Carer Gateway, effective June 2020, will end our capacity to deliver On Fire. One Door has approached several lead agencies funded under Carer Gateway with mixed results; some in favour of the program, some not. One Door urges the Commission to separately articulate and prioritise the unique funding requirements to support young carers, with a view to changing their potentially fraught life-trajectory.

The Federal government has also provided a promising education program for carers of all ages, called “Staying Connected when Emotions Run High”.<sup>12</sup> One Door endorses the ongoing availability of this program for carers, but also for the upskilling the CMO and broader mental health workforce.

## Recommendations 14.1, 14.2, 14.3 - Individual Placement and Employment Support

Recommendation 14.1 requires careful costing and One Door asserts that current funding is inadequate to achieve this. One Door agrees with the need for employment specialists to work with individuals on a one to one basis to: consider the individual’s wellbeing and stage of recovery, and create individualised, supported pathways. In One Door’s experience, most people who would like to obtain employment are not properly supported due to insufficient numbers of skilled staff, and lack of staff in the workplace with mental health expertise. We know that there is also a gap between obtaining employment and “keeping the job”. The biggest issue now is how to best support individuals to continue with their employment.

One Door supports Recommendation 14.2, which encourages of the introduction of New Employment Services to consider the needs of people with mental illness. This includes assessing the potential for online peer group support; considering adaptation of the use of the Job Seeker Classification Instrument so that people reporting a mental illness are referred for personal assessment before being allocated to Digital First; ensuring adequate digital literacy; and ensuring that participants inform service providers of relapse of mental illness in a timely manner. One Door has long been aware of the need for a realistic ‘work test’, where individuals are permitted to work more hours. In same vein, Newstart needs

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<sup>12</sup> Online at <https://www.islhd.health.nsw.gov.au/services-clinics/family-and-carer-mental-health-program/staying-connected-when-emotions-run-high>. Accessed 13/1/2020.

more incentives for people with mental health concerns, such as more flexible rules on job search and participation requirements, and an income test that provides an incentive to work part time. One Door strongly supports an increase in incentives for those on the Disability Support Pension (DSP) to seek work (as proposed in Information Request 14.2)

Further to Draft Recommendation 14.3 regarding the staged rollout of the Individual Placement and Support Model (IPS), One Door endorses programs that provide employment support to those with mental illness. We also encourage the Productivity Commission to consider complementary options such as One Door's Pioneer Clubhouse Transitional Employment Program (TEP). TEPs involve members being offered paid job placement with a local employer for 6 months to develop employability skills including self-confidence, reliability, teamwork, job specific skills, and a work history for their CV. Placements vary from 4 to 20 hours a week. Staff provide active support over the life of the placement. This program also engages local employers in their community, enhancing social responsibility and tripling the bottom line; and helps to break the stigma people with mental illness face in returning to work.

## Draft Recommendation 15.1 – Housing Security for People with Mental Illness

One Door strongly supports Recommendation 15.1 of the Draft Report, which broadly recommends that housing services increase their capacity to prevent people with mental illness from experiencing housing issues or losing their home. This involves State and Territory governments offering and encouraging the use of mental health training for social housing workers, including training to identify early warning signs of mental illness and the benefits of early intervention; review of government policies on anti-social behaviour, temporary absences and information sharing so as to reduce the risk of eviction for people with mental health issues; and ensuring tenants with mental illness in the private housing market have the same access to tenancy support services by meeting the unmet demand for these services. Housing stock should include a mix of private rental, supported housing and alternatives to boarding houses for individuals to settle into long term accommodation that becomes their home. In this context, One Door supports the Housing First model.

## Draft Recommendation 16.1 - Support for Police

One Door agrees with Recommendation 16.1 that more needs to be done in supporting police response to mental health emergencies. We agree that mental health clinicians should be embedded in the police force.

For 10 years One Door has offered training to police through NSW Police Mental Health Intervention Team, with the purpose of providing skills to police to respond safely and effectively to incidents involving people with a mental illness. We recommend that this program is continued, with adequate financial and personnel resourcing.

## Information Request 16.2 - Treatment for Forensic Patients

People in correctional facilities, who also have a severe mental health issue, may get only limited access to mental health services whilst in prison (especially therapy and treatment). One Door agrees this is needed, but we do not have data relating to: the recidivism rate is for people leaving correctional facilities who did not receive the mental health care they required, when compared to the general recidivism rate. Data on the rate of early discharge or delayed discharge for this group is also not easily accessed in the public domain.

The forensic clients we support in our small, successful Forensic Program at Morisset Hospital, receive very high-level care, as they are classified as forensic clients under the Mental Health Act and therefore are not placed in a general correctional facility.

However, people in correctional facilities, who are eligible for forensic mental healthcare, frequently do not receive any (or any substantial or sustained) treatment. Anecdotally, in One Door's experience, people in this situation have very poor outcomes on exit from the facilities, for example: inability to maintain tenancies, and therefore homelessness; increased likelihood of substance misuse; lack of engagement with GPs and other practitioners to seek treatment, including medication and psychological supports; demonstration of frequent challenging or anti-social behaviours; and increased risk of reoffending and return to correctional facilities.

## Information Request 17.1 – Funding the Employment of Wellbeing Leaders in Schools

One Door echoes the suggestion of the Draft Report that there be a mental health trained professional to work within a school setting (Draft Recommendation 17.5). Importantly, this professional should be skilled to work with young people to support their wellbeing needs. Having a professional in schools is particularly important as a significant proportion of mental illnesses tend to arise first in adolescence<sup>13</sup>.

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<sup>13</sup> Kelly, C.M., Jorm, A.F. and Wright, A., 2007. Improving mental health literacy as a strategy to facilitate early intervention for mental disorders. *Medical Journal of Australia*, 187(S7), pp.S26-S30.

This professional does not necessarily need to be provided by the government; many CMOs are well-placed to provide this service themselves. For example, our headspace centre in South West Sydney (headspace Campbelltown) currently runs a well-regarded outreach program at a local high school. This involves a headspace Youth Access Clinician (YAC) being embedded within the school setting one day per week. On this day the YAC conducts the same work as they would at the centre, including intake and initial assessment, referral, as well as providing ongoing support to young people if needed. In this model, the YAC, the headspace Community Education and Development Officer, and a member of the headspace Campbelltown Youth Reference Group (YRG) - who is a student peer mentor at the school - work together to provide wellbeing leadership, destigmatise help-seeking behaviour, and promote available support services.

There is a demand to rollout this program in other local high schools. Anecdotal evidence from our headspace team suggests that young people often prefer working with an external professional, who is perceived as providing more anonymity and confidentiality than a school counsellor/school psychologist, who ultimately reports to the school principal, may be able to provide. This demonstrates that existing CMO supports could be expanded to meet the need for Wellbeing Leaders in schools.

## Information Request 19.2 - Personal Care Days for Mental Health

One Door welcomes this approach, in principle. We employ a high proportion of staff who identify as having a lived experience of mental illness or caring for someone with a mental illness. This brings certain challenges. Carers may need time off for caring duties (such as psychiatrist visits) and people with lived experience of mental illness may experience episodic periods of lower function in their illness. If employers are to employ carers or people with lived experience of mental illness, they require responsive employment workplace policies. Giving staff “personal care” days for caring responsibilities or respite, or due to the episodic nature of some mental illness, would be a welcome development. Rollout of this approach requires dedicated funding and amendments to the National Employment Standards.

## Information Request 25.1 - Data Sets and Indicators

Across the programs provided by One Door, there is an extreme and unsustainable data demand from all levels of government, with multiple departments requiring not only different data, but also different frequency and compulsory use of different platforms. The poorly funded mental health sector bears cost of collecting data and providing it to government. Some types of data that is demanded by different parts of government lack efficacy in achieving the intended aim, for example K10 is a PHN-prescribed tool, which is

not a useful measure because it is a point-in-time measure of distress. Additionally, consumers may be required to complete these measures multiple times in a quarter if they access several services - this is not helpful and reduces the reliability of the measure.

Furthermore, there are multiple tools in use, e.g.; WHOQOL, WHODAS, LSP, RASDS, CANSAS. One Door would welcome a suite of recommended tools so that practitioners and consumers could select those most suitable.

Government does not routinely, nor in a timely manner, return synthesised or analysed data to the CMO sector, let alone to individuals who access services and are the subject of the data. Data that is released to the mental health sector bears a lack of correlation between State data (for example, suicides, presentations at emergency, and hospitalisation rates) and PHN data, which sits in isolation from real time data. There is also under-utilised data on hospitalisation held by LHDs. This culture needs to change.

One Door recommends that data be provided only if it is meaningful in measuring outcomes with and for consumers, and in a format that is readable and accessible, as generated by the CMO's data-platform/s. For example, the people who access One Door's services are supported to develop safety and wellness plans, which are regularly reviewed together with their support workers to monitor progress, adapt goals, and to give a real-time indication of individuals' mental health and needs.

## Recommendation 23.1 - Architecture of the Future Mental Health System

In response to Recommendation 23.1, One Door agrees with that Renovate would not be a preferred option. There are sometimes poor, and sometimes actively competitive, relationships between PHNs and Local Hospital Networks (LHNs). It has appeared to be difficult to achieve open, communicative and collaborative initiatives at the local level. CMOs that provide services in multiple PHN / LHN catchments are confounded by the constraints of different interpretations and applications of guidelines for the same Commonwealth funding pool; with associated data collection and reporting requirements.

PHNs can only use funds received from Department of Health, so this does not truly represent a needs-driven funding approach across Australia, as the Minister can decide where new services are set up. In the past we have seen that some PHNs appear to favour their once-related entities, who are now delivering services; observed through these once-related entities receiving large percentages of the PHN-commissioned funds. This restricts the ability of other service providers to be commissioned by PHNs, even when they have local community service providers providing written support of their proposals. This risk with this model is that service provision is locked in with the biggest service providers, restricting

smaller and potentially more innovative service providers from gaining service contracts. This could create monopolies that may not be in the best interests of the local communities.

One Door supports the Rebuild approach. If Regional Commissioning Authorities (RCAs) genuinely had control of all mental health funding in region, we could achieve significant change in how services are delivered, for example, re-directing funds from inpatient to community care models.

One Door notes that the sector is long overdue for alignment between funding to support people experiencing both mental illness, and substance misuse; including this in the Rebuild design is welcome.

Risks with a RCA approach include that it could be: further removed from the services on the ground, and therefore a less efficient bureaucracy because it is isolated from 'bigger picture' at State and Federal level; unaware of the gaps and opportunities; potentially focused on outputs (for example, the number of available beds) as a primary concern; and less on outcomes (for example, support for recovery in community) as a critical concern.

However, the principle of a single government plan of action and coordinated implementation is sound. Despite possible barriers, the proposed oversight of all mental health funding and commissioning provides hope for consistency and increased system-capacity.

## Information Request 24.1 - Regional Funding Pools

One Door does not believe that the PHNs currently have the knowledge or skills to manage this proposal. MBS funded rebates are not equitable across the country, for example, communities are likely to have more psychologists in wealthier areas compared to less affluent suburbs and rural /remote areas.

Unless significant changes are made to the whole scheme, this proposal would not work - it is not capped, it is not demand driven and psychologists can charge co-payments.

One Door recommends a proper evaluation of the scheme and its effectiveness prior to any change. In conducting an evaluation, the following should be considered:

1. Would the Rebuild model mean that exercise physiologists and dieticians could access PHN funding? If so, there is much benefit in being able to integrate physical health recovery with mental health recovery.
2. Each of the PHNs that One Door holds contracts with is using a different database. Reconciling past MBS rebates could be very problematic. What would be the benefit?

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