



**Mental Health Commission**  
of New South Wales

# Submission to the Productivity Commission

Inquiry into the role of improving mental health to support participation, productivity and economic growth

Mental Health Commission of NSW

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April 2019

*‘Productive systems are those that maximise the whole-of-life outcomes and recovery for people living with mental health issues and support the wellbeing of carers, families and kinships groups. Having access to quality, affordable and accessible services and supports of their choice across the domains of life, will enable people to reach their own goals, participate, live well, and enjoy contributing lives.’*



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### A note on language

#### Productivity

In this submission, the Mental Health Commission of NSW (the Commission) takes a broad whole-of-person lens. The Commission acknowledges that economic participation of people with lived experience of mental health issues and caring enhances productivity and economic growth. In addition, economic participation lifts people, families and communities from poverty and hardship. It helps people hurdle the socio-economic obstacles that can limit their access to the services or supports they need to continue their recovery journey. It can provide independence and choice, which supports personal empowerment and resilience. Stigma and discrimination can also be reduced in the workplace and the community as people get to know and work alongside colleagues with lived experience.

Importantly, the Commission considers that ‘productivity’ encompasses a whole person’s life - participation in community, families, and social networks. This places a value on being a full member of society, being part of something larger, and contributing to and receiving benefits from citizenship. Value is not only measured by economic contribution.

#### Lived experience

The Commission uses the term ‘people with lived experience of mental health issues and of caring, families and kinship groups’ as was preferred by the co-design committee for the *Lived Experience Framework* in 2018. The shorter reference, ‘lived experience’ should be read as the full description. People have told us that the word ‘consumer’ or ‘carer’ does not express their wider experience. In this submission ‘lived experience’ is generally used, but on occasion the terms ‘consumer’ and ‘carer’ are also used where relevant.

## Introduction

### The NSW Mental Health Commission

The Commission was established in July 2012. Its purpose is to monitor, review and improve the mental health and wellbeing of the community by undertaking strategic planning, systemic reviews and advocacy - all guided by the lived experience of people with mental health issues and caring, families and kinship groups.

*The vision of the Commission is:*

*That the people of NSW have the best opportunity for good mental health and wellbeing and to live well in the community, on their own terms, having the services and supports they need to live a full life.*

Of relevance to the Productivity Commission Inquiry, the NSW *Mental Health Commission Act 2012* states:

*“An effective mental health system requires:*

- *a coordinated and integrated approach **across all levels** of government and the nongovernment sector, including in the areas of health, housing, employment, education and justice, and*
- *communication and collaboration between people who have [a **lived experience** of mental health issues] and their families and carers, **providers of mental health services** and the whole community.”*

### The Framing of the Inquiry

#### Assumptions

The Productivity Commission’s (PCs) terms of reference hypothesise that improving mental health supports economic participation and enhances productivity and economic growth. This is underpinned by three key assumptions:

1. mental health is a key driver of economic participation and productivity
2. improving outcomes for people with mental health issues and carers has the potential to impact incomes and living standards and social engagement and connectedness
3. improved population mental health could also help to reduce costs to the economy over the long term.

**Suggestion:** The Commission suggests that the outcomes in assumption two are best decided by people with lived experience of mental health issues and caring, in collaboration with service and support providers. An additional assumption for the review could be:

4. The voice of lived experience is central to determining the outcomes relevant to improving mental health and wellbeing and consequently, social and economic participation.

The economic tenant that consumer demand is central to the market is important in the mental health context. Here the consumer outcomes, being outcomes for people with lived experience of mental health issues and of caring, are central. Core to increasing participation and productivity is the need to refocus services around the needs of people living with mental health issues and their families and carers, embedding the voice of lived experience in every aspect of service planning, funding, design and delivery. A reference for how to do this is the [Lived Experience Framework for NSW](#).

#### Where to act

To understand improving productivity is to see people at the heart of systems and service structures. All three segments are both influencers of and influenced by improved productivity:

- The person and their support people, as consumers of goods and services and individuals with human rights and citizenship entitlements
- The community, as deriving a benefit from positive wellbeing and mental health, and as tax payers
- The economy, as providing the base for thriving people, business and national economic sustainability.

## A medium to long term approach

Over the longer term, with improvements in people's mental health, it may be possible to realise efficiency or productivity gains, as well as savings across multiple sectors such as health, human services and justice. There may be cost savings or efficiency gains to reinvest. This reinvestment, together with additional funding, would contribute to realising structural redesign to address known deficiencies in quality, accessibility and affordability – bridging the service gap, the quality gap, the life expectancy gap and the outcome gap.

## Defining 'value'

The calculation of the value to be derived from good community mental health should include:

- Inclusion, wellbeing, social citizenship, participation, connection to community and supports (including secure housing)
- Improved and positive impact on children's development and wellbeing and upon parenting
- Improved school/education attendance, engagement and completion rates
- Improved social interactions, and reduced contact with the criminal justice system
- Improved physical health and reduced chronic health conditions
- Reduced trauma and distress, and reduced suicide rates
- Reduced need for more expensive mental and physical health interventions and coercive treatment.

## Defining a new paradigm

The traditional model of mental health is based within a biomedical paradigm, with the burden of disease as its key metric. The United Nations suggest that addressing the **burden of obstacles** is a more effective strategy:

To address the grossly unmet need for rights-based mental health services for all, an assessment of the "global burden of obstacles" that has maintained the status quo in mental health is required:

*In order to address the grossly unmet need for rights-based mental health care and support, it is imperative to do an assessment of the global burden of obstacles that has maintained the status quo. **Addressing the burden of these obstacles is a more effective strategy** than the current approach dominating mental health policies and services which focuses on the global burden of disorders neglecting the importance of context, relationships and other important social and underlying determinants of mental health.*

*Dainius Puras, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 6 June 2017<sup>1</sup>*

**Suggestion:** Rather than focussing on the burden of disease for mental ill health, **we propose that reducing the burden of obstacles be the foundation for a future strategy** aimed at improving the mental health of people and the mental health system.

This approach requires systems to make themselves visible and redesign themselves to enable easier navigation by their consumers to optimise the value for consumers and their carers. This system reorientation would take into account the social context and determinants of mental health and support social and economic inclusion and may enhance productivity and economic growth.

The remainder of this submission will focus on identifying the burden of obstacles and ways to shift the focus to what works across foundational elements of system design and core elements of system change.

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<sup>1</sup> Puras, D. 2017. *Statement by Mr Dainius Pūras, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health at the 35th session of the Human Rights Council*. Available from <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=22052&LangID=E>

## Overview

This paper does not attempt to address all the issues raised in the Productivity Commission's **Issues Paper**, but rather presents what we see as the important foundations for system change and longer-term (five - ten years) impact in terms of deriving benefits (and productivity gains) through improved outcomes for people.

### The lived experience lens on productivity

The Commission views *productivity* as being defined by:

- the personal (have I the opportunities to live my life with good physical and mental health and choice?)
- the community (is there population wellbeing, low psychological distress, good health and mental health and opportunities for social and economic inclusion?) and
- the economy (are services resourced, designed and distributed optimally to meet the demands of the consumer without at the same time incurring costs through trauma, discrimination or harm?).

**A lifespan approach to promotion, prevention and early intervention:** In this context it is important to note that productivity gains are not only to be derived for people who are currently in need of mental health services and supports. It is also about providing prevention, promotion and early intervention to reduce the incidence of mental health issues and the progression of an illness throughout a person's life and its severity and the impact for future generations.

**Preventing and treating trauma:** Given the evidence of the association between trauma and mental health issues<sup>2</sup>, a sustainable model of productivity for people and systems must also prevent and treat trauma.

**A local, holistic and integrated approach:** To support productivity, mental health services and supports should be embedded within the communities where people live or play (including schools, workplaces and on-line communities), consider the holistic needs of individuals and carers/support people, and the interaction between health and other areas of people's lives such as housing, employment, education, justice and social services.

**Evidence-informed:** This paper will highlight evaluated, 'evidence-informed' or 'evidence based' programs and approaches and point to studies that provide positive return on investment (ROI) or economic outcomes. It is likely that many submissions will do the same and that the PC will be particularly interested in this type of information. The Inquiry cannot stop here and must look broadly at what constitutes a good outcome or return for people, not only systems and services. People with lived experience must be centrally involved in identifying what outcomes are important, and what constitutes 'evidence', and this may differ from person to person. Not all required supports and services will yield high ROIs, due to scale such as small population groups with complex needs or across large geographic areas, but investment will nonetheless yield productivity gains via enabling people to contribute to building a life of their choice with the people they love, to participate in their communities. For newer interventions such as peer-led services and family-focused models, the evidence is positive but still emerging. These models desired by people with lived experience and services should also be considered.

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<sup>2</sup> For example:

Felitti VJ, Anda RF, Nordenberg D, et al. 1998. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*. May 1;14(4):245-58.

Kezelman C, Stavropoulos P. 2012. *Practice guidelines for treatment of complex trauma and trauma informed care and service delivery*. Kirribilli. Adults Surviving Child Abuse.

Courtois CA, Ford JD, editors. 2009. *Treating complex traumatic stress disorders: An evidence-based guide*. Guilford Press; Feb 5.

Trickett PK, Noll JG, Putnam FW. 2011. The impact of sexual abuse on female development: Lessons from a multigenerational, longitudinal research study. *Development and psychopathology*. May;23(2):453-76.

Mueser KT, Goodman LB, Trumbetta SL, et al. 1998. Trauma and posttraumatic stress disorder in severe mental illness. *Journal of consulting and clinical psychology*. Jun;66(3):493.

Mueser KT, Salyers MP, Rosenberg SD, et al. Interpersonal trauma and posttraumatic stress disorder in patients with severe mental illness: demographic, clinical, and health correlates. 2004. *Schizophrenia Bulletin*. 30(1):45.

Cusack KJ, Frueh BC, Hiers T, et al. 2003. Trauma within the psychiatric setting: A preliminary empirical report. *Administration and Policy in Mental Health and Mental Health Services Research*. May 1;30(5):453-60.

Read J, Os JV, Morrison AP, et al. 2005. Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica*. Nov 1;112(5):330-50.

## Our response

Fundamentally, the directions from the Productivity Commission's Inquiry should take both a long-term view (five-ten years) for measurable system improvement redesign outcomes and recommend a shorter timeframe (one-three years) for co-designing and bringing to scale existing evaluated proven interventions and approaches and investing in the programs with demonstrated return on investment. As outlined above, the process to define outcomes and returns must be co-designed with people with lived experience.

The shorter timeframe should also establish and systemically adopt processes (many of which are outlined in previous reviews, government or sector reports or already exist like the National Mental Health Services Planning Framework) to address the inequities in mental health and associated outcomes across the life domains of people, especially for Aboriginal and Torres Strait Islander people. This immediate three-year period should also establish a strategy to tackle the social determinants of mental health and trauma. The evidence linking social determinants and mental health, suicide prevention issues and poor life outcomes<sup>3</sup> would also infer that unless the circumstances of people is materially changed, improved and targeted investment in mental health will not yield the expected returns and community outcomes over the long term.

All this work can start now. Some is already underway, such as the NSW *Their Futures Matter* program, the *Resolve pilot* social impact bond support program, the *Housing and Accommodation Support Initiative*, and the *Djirruwang Aboriginal health tertiary training program*.

**The results people want:** The clarity of direction and the strength of leadership will, as evidenced by responses to prior national reports, be pivotal to whether the efforts of the Productivity Commission will yield the results that the mental health sector and community want:

- a greater focus on the social determinants of mental health and proven prevention strategies
- reduced impact from mental health issues in daily lives, families, workplaces and across communities
- empathetic systems where every person is treated with respect and dignity and discrimination and stigma are eradicated
- system design where deterioration of mental health to crisis point is not tolerated and early intervention and pathways into services and supports are available in community
- an integrated system where primary care, community based service and hospital based treatments work together to act early in the course of a person's mental health issue or psychological distress and when they are most unwell
- a well trained, diverse, and well supported workforce across settings and service types, with peer workers embedded as a fundamental element of this workforce
- service models that are able to respond sensitively and appropriately whatever a person's identity and background and the challenges they are living with and wherever they go for help
- funding systems that do not set up disincentives to practice or program improvement,
- choice and control over the services and supports they need for their circumstances for people living with mental health issues and carers and families

**The need for a system:** The current system of services and supports is not operating as a system and outcomes for people are often poor across the many domains from which they seek assistance. The system needs to be reoriented and realigned.

**Leadership for a value-based culture:** Culture and values are key and must be in evidence in leadership at all levels of the system. Next to access and availability, what people with lived experience talk to the Commission the most about is the way they are treated by services. The ability of services and workforces to respond in ways that are holistic, compassionate, respectful and dignified depends on leadership at the individual worker and service manager level, but it also depends on decisions made much higher up in the system. Leaders at this level

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<sup>3</sup> See for example: Jorm, A. 2018, 'Australia's "Better Access" scheme: Has it had an impact on population mental health?', *The Australian and New Zealand Journal of Psychiatry*, vol. 52, no. 11, pp. 1057–1062; World Health Organization and Calouste Gulbenkian Foundation. 2014. *Social determinants of mental health*. Geneva, World Health Organization; Allen, J., Balfour, R., Bell, R. & Marmot, M. 2014. Social determinants of mental health. *International Review of Psychiatry*, Aug;26(4).

must demonstrate an understanding of human rights, the impact of trauma, the benefits of recovery oriented and culturally responsive approaches and courage to tackle what is difficult and complex.

**Safe, high quality, culturally responsive and accessible care:** To provide people an adequate level of care, safe, evidence-based components and supports should be equitably available wherever a person lives, no matter their age, cultural background, sexual and gender identity, or abilities.

**Service gaps:** We know that historically there have been significant service gaps in terms of people who need care accessing services.<sup>45</sup> The 2007 National Survey of Mental Health and Wellbeing found that 65 per cent of people who identified as having a mental health issue in the 12-month period did not use services for their mental health needs.<sup>6</sup> Also, 14 per cent of people who did not seek assistance said they were afraid to seek help or were concerned about discrimination.<sup>6</sup> Program effectiveness is eroded if its target population is reluctant to engage.

**Courage to address diversity and complexity:** The Productivity Commission must also demonstrate the courage and perseverance to embrace both the complexity of need of individuals and families/communities and of the system responses to that complexity. All its recommendations must be tested for efficiency, effectiveness and appropriateness across populations with particular vulnerabilities and challenges. The NSW Commission places a priority in working with Aboriginal people; culturally and linguistically diverse communities (established and new and emerging); regional and remote communities; young people; people who identify as LGBTIQ+; people with coexisting physical health issues, drug and alcohol use and/or disability; and people who come into contact with the criminal justice system, to test project findings or outcomes and realise the benefits from engaging with these experts in a co-design model.

**Design and funding:** Shifting funding models will need collective planning, cross sector support and leadership. Nowhere is collaboration more important than in achieving this fundamental element of redesigning and co-designing a more productive system. If funding models do not change, little change elsewhere can be expected. The National Mental Health Commission's report in 2014 highlighted the need and evidence for funding mechanisms that supported the regional delivery of services and supports to the needs of a local population. Pooled funding, integrated care models and co-commissioning are all mechanisms that can support integrated pathways to care and provide choice and control by people.

**Accountability:** Independence and transparency in monitoring and reporting progress is essential. Independent program and investment evaluations are necessary, along with a knowledge exchange system to publish and share the resulting evidence and findings. In NSW, the Mental Health Commission has a legislative role to independently monitor and report on progress with implementation of NSW's ten-year mental health strategic plan, *Living Well* and submit these reports to Parliament. This independent reporting role is a valuable asset to improving transparency in mental health reform outcomes for the lived experience and general community. Such review processes can identify where further efforts are required.

The NSW Mental Health Commission makes the following three overarching recommendations:

**Recommendation 1:** The establishment of a new national approach to the funding of public mental health services and supports, to be integrated with wellbeing and social system investment, to provide mechanisms that drive cross portfolio efficiency and whole-of-life outcomes for people.

**Recommendation 2:** The development of a national mental health and social service sector workforce plan that outlines a framework for education, training and capability development of a skilled and diverse workforce to support improved outcomes for people, services/supports and systems across city, regional and rural Australia.

**Recommendation 3:** The inclusion of a risk analysis of the Productivity Commission's recommendations, to identify the impacts of implementation scenarios from a 'do nothing' to full implementation.

<sup>4</sup> Coghlan R, Lawrence D, Holman CDJ, Jablensky AV. Duty to care: Physical illness in people with mental illness. Perth: University of Western Australia; 2001.

<sup>5</sup> see for example Slade, T, Johnston, A., Teeson, M., Whiteford, H., Burgess, P., Pirkis, J., & Saw, S. 2009. *The Mental Health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing*. Department of Health and Ageing, Canberra, p.12.

<sup>6</sup> Australian Bureau of Statistics. National Survey of Mental Health and Wellbeing 2007. Canberra: ABS; 2012 (Unpublished data). In National Mental Health Commission, 2012: A Contributing Life, the 2012 National Report Card on Mental Health and Suicide Prevention. Sydney, NSW

## A framework for change

The Commission contends that to deliver improved outcomes and productivity for people and the wider community a remodelled mental health system should be built upon the foundational elements of system design and core elements of system change.

The **foundational elements of system design** include:

- 1) planning
- 2) funding
- 3) monitoring
- 4) leadership and governance

The **core elements of system change** that are required to support transformation and sustainability of the system and enhance productivity include:

- 1) participation and leadership of people with lived experience of mental health issues and caring
- 2) integration and coordination
- 3) effectiveness of services
- 4) early intervention
- 5) mental health gateway services
- 6) a skilled and effective workforce.

Our response is presented in two sections:

Firstly, the foundational elements of system design and secondly core elements of system change, with each section outlining:

- our position for change
- the burden of obstacles
- shifting the focus to what works.

When the 'system' or 'services' or 'supports' are discussed, the Commission does not mean narrowly defined mental health clinical or psychosocial interventions. The system is the whole of government and whole of community effort to preventing distress and illness, responding early, and ensuring people have access and control in decision making to have the foundations they require to live full lives of their choice.

# 1: Foundational elements of system design

The Commission contends that effective system (re)design for improving outcomes for people and systems, value-adding to existing infrastructure, and optimising investment is based upon:

1. planning
2. funding
3. monitoring
4. leadership and governance

Getting these components right at the macro level will support system reform implementation, efficient and effective operations, and most importantly, better lives. People with lived experience of mental health issues and caring should be leading and participating in all four components. People have told us they require shared care across organisations, settings and providers.

## 1a) Our position for change – foundational elements

### Planning

- Strengthening consistency and skill in planning by agreeing a consistent national approach to strategic, operational and workforce planning. Train a health and human services planning workforce.
- Establishing mechanisms to enable joint planning at a regional level aligned to care systems or pathways, agnostic of service provider. Joint planning must include all key agencies and people with lived experience.
- Using evidence-based planning tools; person centred health, social and economic intelligence and data analytics; and lived experience based co-design to inform system planning and design.

### Funding

- Funding should be linked to outcomes and need rather than service outputs. Funding approaches must enable effective responses to people with multiple needs and entrenched barriers to access.
- Designing funding models that incentivise collaboration and integration across the whole of the system. It is critical that any funding model supports the overarching vision and person-centred care. Alliance partnerships and co-commissioning at the regional level are an effective way to achieve improved outcomes and impact productivity.
- Supporting evidence-based programs and services via funding models, particularly those related to early intervention where treatment and support is most commonly provided in the community. Earlier intervention ultimately reduces costlier acute services in times of crisis. Early intervention decreases the obstacles people must overcome to enjoy productive, participatory and contributing lives.
- Funding models must incentivise innovation and research, and eliminate disincentives

### Monitoring and reporting

- A holistic monitoring and reporting framework should be developed on the well-established international and national framework, the quadruple aim, measuring improved experience for people, families and carers; improved experiences for service providers and clinicians; improved cost efficiency; and improved health and wellbeing outcomes for the population.
- Key performance indicators should be designed so that organisations and agencies (across settings and providers) are jointly responsible for delivering person-centred outcomes and value.

### Leadership and governance

- Alongside these foundational elements of system design, effective leadership and governance is central to realising systemic change. This involves leadership both within and across organisations for sustainable change and embedding governance structures that support shared accountability and collaborative planning, funding and monitoring, and that involve people with lived experience at the highest levels.
- As stated in the [Gayaa Dhuwi Declaration](#) Aboriginal and Torres Strait Islander presence and leadership is required across all parts of the Australian mental health system for it to adapt to, and be accountable to, Aboriginal and Torres Strait Islander peoples for the achievement of the highest attainable standard of mental health and suicide prevention outcomes.

These elements are foundational to lifting the *burden of obstacles* and *shifting the focus*.

## 1b) The burden of obstacles – foundational elements

Historical ways of working and traditional funding models are no longer fit-for-purpose, evidenced where new specific or targeted programs are frequently ‘dropped’ into the current system to strengthen elements or elevate priorities, rather than taking a systems improvement approach. Quality of life and productivity gains cannot be achieved by maintaining the status quo or ad hoc interventions in relation to how we plan, fund and monitor the system.



### Planning

- **Australia needs an overall consistent approach and qualified workforce to conduct strategic, clinical and workforce planning in mental health.** Government sector guidelines and processes do exist for health facility and service planning and planning tools are available. Non-government organisation (NGO) services are not included in most planning approaches although they are a growing part of the service and support sector and have an increasing workforce.
- **A national process of model of care development, clinical pathway development and then workforce development, needs to be delivered and adhered to.** Mental health clinical services have been allowed to remain siloed. The advances made in other areas of medicine including governance and operations and clinical service development have not been picked up in mental health services because of this. The NSW [Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities](#) identified key deficiencies in this regard:

Review recommendation 1: There is clear international evidence that high performing health services require clinical and collaborative leadership and a patient safety culture. Collaborative leadership was not evident to the review team.

**NSW Health must establish and adopt an integrated leadership development framework applicable to all staff at all stages of their career.**

Review recommendation 3: The integrity of mental health operations and governance is dependent on strong, visible and engaged leadership at the highest level. There is variation in mental health management and accountability structures across the state.

**The Director of Mental Health should be a member of the district or network senior executive and report to the Chief Executive.**

- **Improve the timely accessibility of holistic, integrated data.** Historically, one of the most significant challenges has been the absence of available, timely data to identify needs and use of services and supports across the domains of a person’s life; and to inform evidence-based planning, design, implementation and monitoring. Data collections continue to focus on services rather than the person. However, more recently this data lens is being widened.<sup>7</sup> It is very difficult to design person-centred care and follow a person’s service pathway across the health and human service systems with our existing data and information systems; especially regarding any linkage between primary, community and acute care, and across the health, human service and social support sectors.
- **Improve accountability and investment in planning for Aboriginal and Torres Strait Islander peoples’ needs.** Planning for Aboriginal and Torres Strait Islander peoples’ needs and culturally appropriate service models, is hampered by the lack of relevant information and data. Setting targets, such as a mental health target under the Closing the Gap, would assist in driving improved information system design and collection.

<sup>7</sup> Examples include: The Your Experiences of care (YES) survey was adopted in NSW in 2015; the Australian Bureau of Statistics’ (ABS) 2014 *Mental Health Services-Census Data Integration* data set linking the 2011 Census data with usage of mental health-related Medicare Benefits Schedule (MBS) services and Pharmaceutical Benefits Scheme (PBS) prescription medication.



- **Employ transparent, cross government portfolio planning and funding decisions.** The Australian and State and Territory Governments all bear the risk of avoidable costs arising from poor coordination of the delivery of mental health services. Cross organisational interactions are particularly complex in delivery and support provided to people with mental health issues and carers and families. Government cross portfolio funding decision processes which accord with best practice evidence and ROI are not always clearly evident or consistently applied within an overarching mental health and wellbeing paradigm, yet there is evidence that investment across the domains of a person's life in family support, housing, employment or early childhood resilience have pay-offs for mental health later in life.<sup>8</sup>
- **Adequately fund community based mental health services.** There exists a shortage of resources particularly in relation to community based mental health services and funding.<sup>9</sup> These resources are necessary to have a well-designed system of care, in which each element is resourced as to its delineated purpose, speciality role and population demand. For system efficiency and management, clinicians rely upon the availability of quality, accessible and safe services to refer their clients to. Without these, risk is carried by mental health clinicians in the decision-making process in relation to risk management. Where safe and appropriate alternatives in the community do not exist, the consequences of under provided community-based alternatives can lead to involuntary admission to hospital. In this scenario, funding levels are directly linked to both quantity and quality of care, and to the context of clinical decision making. This paradigm has to shift if we are genuinely proposing a change in the equation - simply increasing capacity in the community without quality safeguards may not move the balance of this admission equation.
- **Adequately fund and strengthen the capacity of the workforce delivering community based psychological rehabilitation and supports.** Similar to specialist (public) mental health services, there has been limited investment in psychosocial rehabilitation and support services often provided by the community managed sector<sup>10</sup>. Investment in workforce development alongside expanded community care options is a priority: in training and education in new service models; collaborative frameworks; and, in emerging workforce groups such as peer workers or specialist groups such as the Aboriginal and Torres Strait Islander workforce.
- **Better understanding of costs and outcomes of services (for people and service systems) across the spectrum of care is urgently required to achieve sustainability and informed investment.** Robust business modelling and consideration of how initiatives can become financially sustainable is important. Current funding arrangements are not conducive to reorienting care to early intervention in community settings rather than acute service settings. The exploration of alternative funding packages and funding incentives are required and are essential for reform.
- **Use the MBS to leverage better use of private mental health service providers.** Community based services are also importantly provided by clinicians in private practice, where expenditure through the Medical Benefits Schedule (MBS) is significant. While the inequitable geographic distribution of specialist mental health practitioners acts as a barrier to people accessing specialist interventions, likewise availability of bulk billing clinicians also acts as an affordability barrier to receiving appropriate mental health interventions. Some current inflexibility in the structure of the MBS presents a barrier to community care as well as difficulty in accessing, even in metropolitan locations, psychiatrists and psychologists who do not charge above the scheduled fee.

<sup>8</sup> See: <https://www.mhcc.org.au/wp-content/uploads/2018/11/MH-Matters-Future-Investment-Priorities-for-NSW.pdf>; <https://www.childabuseroyalcommission.gov.au/sites/default/files/WEB.0189.001.1036.pdf>; [https://mhaustralia.org/sites/default/files/docs/investing\\_to\\_save\\_may\\_2018\\_-\\_kpmg\\_mental\\_health\\_australia.pdf](https://mhaustralia.org/sites/default/files/docs/investing_to_save_may_2018_-_kpmg_mental_health_australia.pdf)

<sup>9</sup> In 2016-17 per capita expenditure on community mental health care services in NSW was \$71.90 compared to the national average of \$85.78 per capita. <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/data> Table EXP.4: Recurrent expenditure per capita (\$) on state and territory specialised mental health services, constant prices, states and territories, 1992–93 to 2016–17

<sup>10</sup> In 2015-16, NSW allocated 6.8 per cent to Community Managed Organisations, compared to the national figure of 13.19 per cent. <http://www.mhcc.org.au/wp-content/uploads/2018/11/MH-Matters-Future-Investment-Priorities-for-NSW.pdf> page 4.

### Income support payments

- **Income support must be designed to facilitate stepped re-engagement with workplace participation and demonstrate a recovery orientation with in-built flexibility in workplace engagement at no disadvantage to the person.** People with mental health issues seeking employment face a multitude of significant barriers. Inflexibility in the Disability Support Pension (DSP) to support flexible return to work options, or stepped employment is one such barrier. People fear losing the DSP if they undertake employment or training. They may not feel secure about their wellbeing to support ongoing employment and are deterred by having to reapply if they lose the pension. These are obstacles to participation, improved financial situation and inclusion in workplaces and communities, all of which are elements of a person's recovery.
- Barriers to applying for the DSP reflect a lack of a customer focus. This sets up an environment which does not account for the impact of a person's psychosocial disability upon their ability to navigate through bureaucratic processes and the episodic nature of mental health issues. Many people with mental health issues will have a trauma experience. The way they are related to with regards to income support and employment services may further exacerbate their distress.
- Even with access to the DSP, financial stress will continue for many people living with mental health issues. System design and funding must allow for access to clinical services and community activities that support recovery.
- The Commission sought views from a small number of carer support workers about the barriers they hear about in accessing income support by carers. These issues include:
  - Centrelink is not an easy agency to deal with and causes significant frustration and additional burden.
  - Forms are not fit for purpose for people caring for someone with mental health issues and are overly burdensome
  - It is difficult to prove eligibility for income support when the person being cared for lives outside the carer's home or when their illness is episodic.
  - Eligibility for income support is too onerous. The Carers' Allowance is insufficient.



### Monitoring

- **Monitoring and reporting on efforts for reform, including future recommendations for reform, must continue to be funded and strengthened.** A barrier to implementation of current and future recommendations for reform, is the poor and/or inconsistent monitoring and public reporting on progress. The series of National Mental Health Plans, leading up to the current Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan), historically have not established a complete data set to measure agreed KPIs under the Plans to monitor implementation and report on progress. This has a twofold effect – reporting and collection systems have not matured to systematically collect outcomes and experiences of services and supports across the domains of a person's life, and therefore system managers, funders and planners have no direct analysis upon which to base informed decision making across government or across sectors. However, efforts are underway, such as with the development of a data strategy, the roll out in the mental health public sector of the *Your Experience of Service* survey and linked data projects such as the Australian Bureau of Statistics' *Mental Health Services-Census-Mortality Integrated Dataset* based on the 2011 Census. Higher prioritisation and funding of such work is required.

- **Ensure rigorous monitoring of safety and quality standards, including outcomes that are important to people with lived experience, in both hospital and community settings.** The 2017 *Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities* highlighted some deficiencies in monitoring in hospital settings. Monitoring must focus on the outcomes that are important to people with lived experience, and the enablers of reform and practice improvement. More needs to be done to improve the safety and quality of care for people with mental health issues who require hospital services. Given the necessary future investment in community based and community managed services' role in service provision, safety and quality standards need to follow the patient/client, wherever they access services or supports. Future funding models should incentivise improved practice and safety and quality across all service settings.
- **Evaluation must be improved to better understand the outcomes of investment for people and across portfolios.** Robust monitoring of investment and person, community and service outcomes, needs to be matched by robust evaluation systems. There is limited insight into costs, benefits and quality of services across the whole care economy. This lack of information is a challenge to informing decisions to strengthen prevention, early intervention and care in a community setting, and for evaluating the financial and human benefits. As effective evaluation frameworks measure benefits across domains (e.g. housing, physical health, mental health) so too mental health budget planning should be cross government and whole of government.



## Leadership and Governance

- **Strong leadership in responding to lived experience and implementing reform is central to redesign and reform and is required at all levels.** It can be both the strongest enabler and obstacle to reform. Leadership for implementation is often missing. Policy documents, strategic plans and roadmaps abound. What is often missing is leadership and skilled oversight of the implementation of these policies. Any recommendations made by the Productivity Commission must be accompanied by an implementation, resourcing, risk management and a change management plan.

## 1c) Shifting the focus to what works – foundational elements

Realigning service and funding models requires process change, program redesign and a cultural shift to embedding lived experience. This is fundamental to redesigning for improved outcomes measured against, personal, system performance and economic metrics.



### Planning

- **Base planning on lived experience involvement and co-design.** Effective community involvement is an essential component of building well integrated and person and family centred services and supports. It requires engaging people with lived experience, carers and families in planning, designing and evaluating services.
  - The NSW Mental Health Commission released *The Lived Experience Framework* in December 2018. The Framework encourages service providers to embrace the rich knowledge that lived experience can bring to service design, delivery, monitoring, evaluation and improvement activities.
- **Strengthen consistency and skill in planning** - by agreeing a consistent national approach to strategic, operational and workforce planning that aims at consistent service offerings across Australia. Train a workforce through developing an accredited health service planning tertiary course (or accredited modules) that includes mental health planning and incorporates strategic, operational and workforce planning
- **Require joint planning.** Improved whole of system integration must involve all key organisations and groups in joint planning so that there is agreement on shared priorities and investments are coordinated and aligned. These include all levels of government, plus: people with lived experience, local health networks/districts, primary health networks, professional groups, local councils and community organisations, consumer and carer groups, the community managed sector and other providers across the social and human services sector.
  - Implementing joint regional PHN and LHN/D planning (a Fifth Plan priority) will provide a mechanism to integrate service planning and delivery and make the best use of local resources and expertise.
  - The next step, as called for in the 2014 national Review of Mental Health Services and Programmes, is establishing pooled funding mechanisms where shared outcomes, monitoring and evaluation can occur.
- **Use evidence-based planning tools.** The National Mental Health Services Planning Framework (NMHSPF) covers the full spectrum of services and interventions from promotion and prevention, primary care services, and community support services through to the most intensive and specialist services. It models an evidence-based service mix that places greater emphasis on services delivered in the community and a shift to broadening towards subacute or step-up/step-down services. The NMHSPF provides a clearly documented and evidence-based taxonomy providing specific details of services and projections. However, this important planning tool it is not available to users in NSW outside of the public mental health services.
  - As the NMHSPF provides outputs such as occasions of service and client related staff hours by client age and setting, it is a useful tool to inform planning for an evidence-based mix and level of mental health services rather than making decisions mainly based on historical service delivery. The outputs from the NMHSPF can be used in conjunction with other data and planning tools to inform clinical services plans and workforce plans. Importantly it must be used in conjunction with data and evidence provided by the experiences and preferences of people with lived experience.
  - Broadening such a tool to encompass domains across a whole of person and carer mental health framework, could model the impacts of housing, education, justice, employment participation, connection with community, crisis services and income support and enable costs and benefits to be identified and accounted for in planning and funding.

- **Increase use of patient centred health intelligence and data analytics.** Our health intelligence systems are increasing in sophistication to support new ways of planning service and support systems around the person, rather than the service. Using data analytics, economic modelling and simulation modelling will better inform planning.
  - Data linkage, such as used in the NSW program *Their Future Matters*, can provide a more holistic view of a person's journey. These types of data can then be used as inputs to simulation modelling and economic modelling to inform future planning.



## Funding

- **Invest for the vision of mental health reform.** Investments need to be aligned to the reform vision, informed by joint planning, and evidence of what works. This should consider the whole system rather than looking at individual services in isolation, and likewise consider people as part of families or kinship groups, social networks and communities and not in isolation. Processes are required to make clear and transparent decisions about what will/will not get funding, ensuring value, avoiding duplication, and ensuring delivery by the most appropriate provider at the right time and place for the person. There also needs to be opportunity for funding innovative frontline improvement initiatives.
- **Link funding to outcomes and need** – focussing upon reducing inequities in access and health and wellbeing outcomes and optimise the effectiveness of funding models.
  - Funding models should be structured on the principle of proportionate universalism, to address lifting outcomes for the more vulnerable populations, for example through resourcing high quality and culturally appropriate early childhood services for Aboriginal and Torres Strait Islander children under 5 years old. The weighting used in Activity Based Funding for rurality, Aboriginal and Torres Strait Islander community need, and children and young people is a good example that could be applied to services and supports delivered in the community.
  - Opportunities to strengthen system funding mechanisms for rural and semi-rural service needs must be explored. The circumstances of workforce numbers and expertise availability, distance and accessibility, rural adversity and socioeconomic disadvantage which are found variably across rural Australia, need to be recognised in funding models to provide a sustainable resourcing platform and secure improved outcomes for those communities.
  - Funding mechanisms need to incentivise early intervention, addressing mental health issues early in their trajectory in community and primary care settings and ultimately avoiding the development of mental health crises. This would reduce the personal and health costs of experiencing a mental health crisis upon the person and their family and carers, and the economic costs on acute care and first responder systems.
  - Funding mechanisms should enhance workforce effectiveness - funding through the MBS should be reviewed to remove caps where these impede outcomes and add items that encourage multidisciplinary approaches. Funding approaches must enable effective responses to people with multiple needs and entrenched barriers to access.
- **Use alliance partnerships and co-commissioning of services.** Strategic commissioning aims to strengthen partnerships and service outcomes, better align services with priorities, enhance service quality, and improve effectiveness and value for money. There are a growing number of examples of how alliance partnerships can support integration and outcomes. Alliance partnerships are also proving to be an effective way of bringing stakeholders together to develop integrated solutions and enhance program reach and support to those who need it most. Local alliances should comprise people with lived experience, LHDs, PHNs, local councils and community organisations, consumer groups, CMOs and providers. Alliance partnerships would be responsible for: regional joint needs analysis and service development, finance (including flexible provider funding arrangements), public reporting and outcomes measurement. Initiatives have been identified or underway, upon which the Productivity Commissions can draw upon.

- The 2014 National Review of Mental Health Services and Programmes discussed regional funding models and how funds can be better reinvested.<sup>11</sup> Regional funding models can be used to shift the model of care in Australia from one focused on supply to one focused on the needs of individuals and local communities.
- The Fifth Plan recommends PHNs and local health networks explore innovative methods to improve efficiencies, sustainability and outcomes for people with lived experience. Joint commissioning of health services may be one option. Some LHDs are working with PHNs on pilot initiatives such as shared intake and referral pathways to improve consumer experience and system efficiencies. To be successful these types of collaborations need effective leadership, thorough planning and adequate resources allocated.
- The Commonwealth-NSW Coordinated Care Bilateral Agreement 2017-19 supports joint PHN and LHD/SHN commissioning of mental health services. The Bilateral Agreement also seeks to improve coordination in mental health service and policy planning and strengthen workforce capacity across primary, aged care and specialist mental health sectors.
- Contestability has already been introduced by NSW Health to some mental health programs delivered by community managed services outside of Partnerships for Health. These include Community Living Supports (CLS), Housing and Supported Accommodation Initiative (HASI), Suicide Prevention Fund, and the LikeMind pilot. In these arrangements, unintended consequence for clients and the sector need to be factored into the initial planning and identification of risks and outcomes. The Commission has heard from clients and CMOs alike that service disruption and client support worker relationship breakdown as a consequence of change in provider, has caused stress and distress to clients, their families and supporters and the workforce of those organisations. Therefore, funding models need to recognise that they operate within human systems and change can adversely affect service engagement by clients – a severe and important unintended consequence.
- **Consider a social outcomes funding approach** – In NSW Their Futures Matter (TFM) Investment Approach provides flexibility in NSW service design to deliver improved outcomes for vulnerable children, young people and their families. The breadth and depth of the NSW Human Services Data Set and TFM Social Outcomes Model provides insight into service usage and future outcome trajectory of the population focussed upon under TFM. This provides the opportunity for packages of service and intervention to be funded and designed around specific needs, not bound by silos of agencies, to address the complex needs of those most vulnerable in NSW. It also offers the ability to commission partners and services based on proven evidence and outcomes. This Investment Approach results in the development of cross agency support for vulnerable children and their families, particularly for those with complex needs who require a mix of tailored agency services from a range of providers.
  - Linked with a social outcomes model across agencies, the TFM Investment Approach has direct parallels with the challenges of designing mental health and wellbeing funding models that address complexity, are designed to meet specific community needs and shifts funding decisions to a collaborative model.
  - The Productivity Commission should consider the TFM approach, the learnings from its implementation and benefits from cross agency coordinated investment to achieve shared outcomes
  - TFM now has the operating model (Family Investment Model) fully functional and has the capacity to inform government of emerging trends, service provision and gaps along with financial investments into the sector to meet vulnerability demand.

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<sup>11</sup>National Mental Health Commission, 2014: *The National Review of Mental Health Programmes and Services*. Sydney: NMHC <http://www.mentalhealthcommission.gov.au/our-reports/our-national-report-cards/2014-contributing-lives-review.aspx>



## Monitoring

- **Measurement, monitoring and evaluation will be a critical element of any recommendations for reform.** This includes understanding any shift in the resourcing and redesign of the system, the impact on quality of life, impact on recovery opportunities, productivity and the derived value in health care and across the system. The development and utilisation of joint key performance indicators will be required. A central set of mental health and wellbeing outcomes should be developed to support standardisation of data where required.
  - The NSW Mental Health Commission is currently developing a suite of indicators to monitor implementation and outcomes of mental health reform in NSW. These indicators cover three key domains: a system of high quality support, people living well and thriving communities. Under its legislative responsibilities<sup>12</sup>, the NSW Commission monitors, reviews and reports to Government on progress with mental health reform, and on the mental health and wellbeing of the people of NSW.
- **Monitor and report outcomes rather than outputs.** Performance measures must align to the vision and strategy and this will require monitoring focused more on 'outcomes' and 'impacts' rather than 'inputs' and 'outputs'. Whole of system performance measures are preferable to measures that reflect service performance in isolation.
  - Monitoring and reporting must be supported by an independent evaluation and reporting mechanism.
  - A cross agency social outcomes approach would support development of an overall system strategy, priorities and resource allocation required to achieve the shared outcomes.
- **Support data sharing and evaluation of models.** Better data sharing could better target responses. Additionally, long term evaluations that measure a range of mental health, health, social determinants and community participation measures are required to determine the benefits and contribution of the reforms and the cost efficiencies and productivity gains to the system and to people.



## Leadership and Governance

- **Identify clear governance structures and mechanisms for accountability.** Clear accountabilities and governance frameworks are essential between governments to ensure systematic, collaborative monitoring and reporting to chart progress and identify 'wins' over time. The keys to success of cross agency governance structures such as that provided by COAG and the NSW Mental Health Taskforce should be identified and empowered. The potential of shared outcome frameworks such as the NSW Human Services Outcomes Framework should be explored and built on.
- **Ensure transparent, frequent and relevant public reporting on implementation.** This will be necessary to ensure strong governance and accountability to people with lived experience, the workforce, service and support providers and the community.
- **Leadership to support innovation in new funding and service models will also be foundational to improving mental health to support participation and productive outcomes.** In NSW the *Resolve* social impact bond five-year trial implemented by Flourish Australia, which aims to provide community based assertive support for people who have a history of significant hospital admissions, is already at year 1 showing positive results.<sup>13</sup> The NSW Commission points the Productivity Commission to the submission made by Flourish Australia.

<sup>12</sup> Mental Health Commission of New South Wales Act, 2012, as amended 22 November 2018  
<https://www.legislation.nsw.gov.au/#/view/act/2012/13/full>

<sup>13</sup> Social ventures Australia. 2019. *Resolve Social Benefit Bond. Annual Investor Report. Period ending 30 September 2018*. Available 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)

- **Ensure priority resourcing for Aboriginal leadership for improved social and emotional wellbeing.** The five key actions of the Gayaa Dhuwi Declaration<sup>14</sup> should guide the recommendations made by the Productivity Commission in relation to Aboriginal and Torres Strait Islander social and emotional wellbeing:

1: Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing should be recognised across all parts of the Australian mental health system, and in some circumstances support specialised areas of practice.

2: Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing combined with clinical perspectives will make the greatest contribution to the achievement of the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples.

3: Aboriginal and Torres Strait Islander values based social and emotional wellbeing and mental health outcome measures in combination with clinical outcome measures should guide the assessment of mental health and suicide prevention services and programs for Aboriginal and Torres Strait Islander peoples.

4: Aboriginal and Torres Strait Islander presence and leadership is required across all parts of the Australian mental health system for it to adapt to, and be accountable to, Aboriginal and Torres Strait Islander peoples for the achievement of the highest attainable standard of mental health and suicide prevention outcomes.

5: Aboriginal and Torres Strait Islander leaders should be supported and valued to be visible and influential across all parts of the Australian mental health system.

The NSW Commission points the Productivity Commission to the submission made by the National Aboriginal and Torres Strait Islander Leadership in Mental Health.

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<sup>14</sup> National Aboriginal and Torres Strait Islander Leadership in Mental Health. *Gayaa Dhuwi (Proud Spirit) Declaration*. Available at [https://natsilmh.org.au/sites/default/files/WEB\\_gayaa\\_dhuwi\\_declaration\\_A4-2.pdf](https://natsilmh.org.au/sites/default/files/WEB_gayaa_dhuwi_declaration_A4-2.pdf)

## 2: Core elements of system change

The core elements of system change describe what is required to support transformation and sustainability of the system. It is important to note that no one element sits in isolation; rather each element is dependent upon the development and implementation of other elements and the foundations of planning, funding, monitoring and leadership. All six elements will work together to improve outcomes for people and systems:

- 1) participation, influence and leadership of people with lived experience
- 2) integration and coordination
- 3) effectiveness of services
- 4) early intervention
- 5) mental health gateway services
- 6) a skilled and effective workforce

### 2a) Our position for change - core elements of system change

#### Participation, influence and leadership of people with lived experience

- Mental health and social services must be truly centred on the people who use them and supportive of their individual journeys of recovery. To achieve this, embrace the participation, influence and leadership of people with lived experience of mental health issues and caring, families and kinship groups in service design, delivery, monitoring, reporting, research, evaluation and improvement activities.
- As articulated in the Lived Experience Framework<sup>15</sup>, there are three focus areas for the actions required to achieve change: shift the usual ways of doing things, cultures and assumptions; demonstrate leadership commitment and action; and refocus policies, resources, education and employment opportunities and structures.

#### Integration and coordination

- Accelerate and incentivise whole of system collaboration and integration through the implementation of new funding and purchasing models at the regional level.
- Build upon mechanisms and structures established to support joint planning, funding and monitoring and establish regional partnerships at the service delivery level to improve integration and coordination.
- Co-production and lived experience are essential components of all partnerships.
- Scale-up and resource evidence-based community based mental health programs and services to support people to live productive lives in the community.
- Improve mental health literacy of workforce across human services.
- Implement evidence-based initiatives to support housing stability and prevent homelessness.

#### Effectiveness of services

- Leverage new data systems and technology, including data linkage and client experience surveys, to strengthen the evidence base and support system level decision making.
- Establish a central evaluation register to increase transparency and accountability of evaluations relevant to mental health and wellbeing, to contribute to the evidence base and act as a knowledge exchange.

#### Early intervention

- Shift the focus of mental health programs and service delivery to evidence-based prevention and early intervention, implementing programs across the system in a comprehensive way to reduce pressure on acute care, increase lifetime wellbeing and productivity and reduce reliance on income support.
- Intervene early with population groups at risk of interaction with the criminal justice system through the implementation of evidence-based programs.
- Implement suicide prevention frameworks and associated actions with a focus on 'at risk' population groups, in particular implementing 'aftercare' models following an episode of self harm.

<sup>15</sup> Mental Health Commission of NSW. 2018. *Lived Experience Framework for NSW*. [nswmentalhealthcommission.com.au](http://nswmentalhealthcommission.com.au)

**Mental health gateway services**

- Implement models and funding incentives to ensure a 'no wrong door' approach offering people with mental health issues and carers and families or people at risk appropriate assessment, treatment and/or referral in the setting first encountered.

**A skilled and effective workforce**

- Utilise workforce data and evidence-based tools to inform workforce requirements and align funding to more appropriately resource the mental health workforce, particularly in areas of need, for new and emerging workforces, the peer workforce and Aboriginal health workers.
- Provide necessary capability training, supervision and structures to sustain workforces supporting people with mental health issues to reduce stress and burnout, maintain positive cultures, and increase workforce participation.
- Support the continued rollout of Mentally Healthy Workplaces to promote wellbeing in the workplace and support a productive workforce.

## 2b) The burden of obstacles – core elements of system change

The obstacles to system change are those that hinder collaboration, integration and collective impact.



### Participation, influence and leadership of people with lived experience

- **Take up opportunities to redesign fit-for-purpose services by ensuring the participation, influence and leadership of people with lived experience.** A 2015 Australian review found that “A body of literature is slowly accumulating which suggests there is growing recognition by governments and health and community leaders of the need for a more active role for consumers in their own health and wellbeing and the development of local services. Consumer engagement is known to improve both the quality and safety of health services as well as individual health outcomes, whilst also making health services more responsive to the needs of consumers.”<sup>16</sup>
- **Identify and address barriers in the system and services to greater involvement by people with lived experience.** Barriers to increased participation, influence and leadership are significant. Leadership is required to overcome a culture that does not accept that the benefits of including lived experience outweighs the challenges to undertaking meaningful engagement. Stigma will be a continual barrier. Time and cost<sup>17</sup> of setting up organisational structures that involve people with lived experience is a further barrier. The Commission is often advocating in the face of cultural and logistical barriers for agencies in NSW to recognise lived experience expertise through paid participation.
  - Some people with lived experience of mental health issues may have additional disadvantages that mitigate against their ability to become involved in participation, influence and leadership of the system. Paid participation will help ameliorate some of these barriers. Good mental health care will also assist, including for carers who can be freed to take up advocacy and leadership roles. Services and system agencies must however, be open and curious and flexible in ensuring people with lived experience are able to give full voice to their views and expertise. Safe and accessible places and mechanisms for participation, influence and leadership are essential.
  - The barriers to the full flourishing of the peer workforce are well documented.<sup>18 19 20</sup>

<sup>16</sup> Lavery, S., 2015. *Consumer engagement in Central Victoria. A literature review for health and community Services.* Central Victorian Primary Care Partnership: Castlemaine. P 4

<sup>17</sup> Lavery, S., 2015. *Consumer engagement in Central Victoria. A literature review for health and community Services.* Central Victorian Primary Care Partnership: Castlemaine. P 4.

<sup>18</sup> Queensland Mental Health Commission. 2017. *Barriers and enablers to lived experience workforce development.* [https://www.qmhc.qld.gov.au/sites/default/files/qmhc\\_summary\\_barriers\\_and\\_enablers\\_to\\_lived\\_experience\\_workforce\\_development.pdf](https://www.qmhc.qld.gov.au/sites/default/files/qmhc_summary_barriers_and_enablers_to_lived_experience_workforce_development.pdf)

<sup>19</sup> Gordon, J. 2014. *What are decision makers' barriers, facilitators and evidence needs regarding peer support working?* A report commissioned by the Scottish Recovery Network.

<sup>20</sup> Vandewalle, J., Debyser, B., Beeckman, D., Vandecasteele, T., Van Hecke, A. and Verhaeghe, S., 2016. Peer workers' perceptions and experiences of barriers to implementation of peer worker roles in mental health services: A literature review. *International Journal of Nursing Studies*, 60, pp.234-250.



### An uncoordinated system

- **Improve integration and coherence in the mental health system.** Mental health systems are siloed, there exists numerous system overlaps and a lack of coherent pathways. The degree of fragmentation in mental health has impacted on communication between services leading to duplication of assessment and people falling through the gaps.
  - Knowledge of service providers across the system is variable and therefore support to access other services is also variable. There is a general lack of co-ordination between physical and mental health services, and health professionals outside mental health services do not generally engage with people's mental health conditions. Given the high levels of co-existing illnesses and the reduced life expectancy of people with severe mental illness, such poor practice is unacceptable and is a cost carried by people and services.
  - Integration of care and coordination across providers and sectors is required to support optimal outcomes for people living with mental health issues.

### Health Literacy

- **Improve health literacy.** Low health literacy has been associated with less participation in prevention activities, less effective communication with healthcare professionals and increased healthcare costs.<sup>21 22 23</sup>  
<sup>24</sup> Service approaches need to recognise this service context where sixty percent of Australians have low health literacy.<sup>25</sup>

### Transitions

- **Design solutions to fill gaps and address risks that arise during transitions.** The transitions of care or transitions between life stages are some of the most vulnerable and difficult times for a person with mental health issues, their family and carers. Co-ordination across and between services, and with the person and their supporters is important to ensure services remain relevant to the stage in the person's life and so keep them engaged with their mental health supports as well with participation in education, training, work or social activities. Disconnection from services at transitions can break therapeutic relationships and disengage people from supports and activities which support their wellbeing and social development.
  - With half of mental illness occurring before age fourteen and 75 per cent presenting before age 24<sup>26</sup>, young people are especially at risk of disengaging from education, work opportunities and social networks. Transitions are challenging for children and young people moving between primary and high school, high school and further study/training and further study/training and the workplace, and impact upon participation in community and workplace activities, future earning capacity and independence.
  - Transitions later in life are also a time of risk due to loss of workplace connections, close relationships and independence. It is also a time when criteria and eligibility for mainstream services may change.

<sup>21</sup> Von Wagner C, Knight K, Steptoe A, Wardle J: Functional health literacy and health-promoting behaviour in a national sample of British adults. *J Epidemiology Community Health* 2007, 61(12):1086-1090.

<sup>22</sup> Adams RJ, Piantadosi C, Ettridge K, Miller C, Wilson C, Tucker G, Hill CL. 2013. Functional health literacy mediates the relationship between socio-economic status, perceptions and lifestyle behaviours related to cancer risk in an Australian population. *Patient Education Counselling*, 91(2):206-212

<sup>23</sup> Schillinger D, Bindman A, Wang F, Stewart A, Piette J. 2001. Functional health literacy and the quality of physician-patient communication among diabetes patients. *Patient Education & Counselling*, 52(3):315-323

<sup>24</sup> Herndon JB, Chaney M, Carden D. 2011. Health literacy and emergency department out-comes: a systematic review. *Annals of Emergency Medicine*, 57(4):334-345

<sup>25</sup> Australian Commission on Safety and Quality in Health Care - <https://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/health-literacy/>

<sup>26</sup> Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., Walters, E.E. 2005. Lifetime Prevalence and Age-of-onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*. 62(6):593-602.

### *Housing and homelessness*

- **Prioritise housing as the basis for recovery and participation.** For recovery to be a successful process, people need safe and stable housing. Housing insecurity and homelessness is therefore a significant barrier to a recovery focused and productive life for people living with mental health issues and carers, families and supporters.
- **Address the financial and system capacity barriers to stable housing for people with mental health issues.** Many people with lived experience on low incomes report living in unstable and marginal housing such as boarding houses, backpacker accommodation, crisis accommodation, pubs and other forms of temporary housing. People also report that obtaining public housing was difficult because of long waiting lists and the burden on individuals to “continually prove their needs and advocate for their ‘case’”.<sup>27</sup>
- **Incentivise best practice discharge from hospital.** The system impacts of insecure housing are no more apparent than when people are waiting in hospital (including forensic hospitals) for discharge but are delayed due to lack of accommodation. It is not unusual for local health districts to find alternatives such as short stay motels, that only provide an interim option for people, to secure a discharge. It should be noted that there are existing KPIs for lengths of stay in hospitals and for not discharging people into homelessness. However, these do not always prove to be incentives for best practice to ensure a person has accommodation from which they can receive community follow-up or home visits. Co-ordination across services, integrated with the persons mental health supports would be a game changer in achieving the best outcome for the person, irrespective of the provider of the supports they need.

### *National Disability Insurance Scheme (NDIS)*

- **Address the gaps and unintended consequences arising from the implementation of the NDIS for people with mental health issues.** The NDIS presents a unique opportunity to change the lives of many people, through the provision of wrap around services, of their choice. The Commission understands that some NDIS recipients and their carers, are unsure as to how these services will integrate or be co-ordinated with other services they may access. Additionally, service gaps exist for people with psychosocial disability who do not qualify for the NDIS. While there have been recent announcements by the Commonwealth to clarify and fund services to meet these gaps, for individuals, it will be important to have these operate as part of a co-ordinated system of supports. Alongside this, it will be fundamental to ensure that the best opportunities for best value for clients and the NDIS system are also aligned with equitable access to the scheme. This is compounded by reports of the variable skill levels of NDIS planners, the lack of expertise to support people with lived experience of mental health issues and challenges for Aboriginal people with mental health issues in accessing the NDIS.

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<sup>27</sup> NSW Consumer Advisory Group Mental Health Inc. (2012). *Border to Border: Visions of hope: A report to the NSW Mental Health Commission*. Sydney, NSW Consumer Advisory Group Mental Health Inc.



## Effectiveness of services

- **Ensure independent and transparent evaluation of programs and services.** Maximising value for money requires knowing what is effective, for whom, under what circumstances, and how to deliver effective care most efficiently. Evaluations are currently managed by a range of government agencies and organisations and findings, either positive or negative, are often not shared more broadly to support improvement. Service effectiveness assessment is reliant upon independent evaluation of program outcomes and of the delivery of interventions. The 2014 National Mental Health Commission Review identified a lack of available program evaluations for many Commonwealth funded mental health programs. Of fifteen programs, ten had evaluations while the remainder had no or partial evaluations or they were underway. These five programs represented nearly \$172m in Commonwealth funding.<sup>28</sup> One Australian study on the quality of mental health treatments found that of people with a mood or anxiety disorder who sought professional help, only 26 per cent received an evidence-based treatment.<sup>29</sup>
- **Improve access to data.** In Australia, barriers to understanding the continuum of care result from health and social-economic data being collected by different levels of government and private organisations. Access to data is often problematic, with relevant data sets hosted by a range of different organisations in different formats, there is variation in the availability and quality of data and organisations use different measures for the same outcome, which limits the ability to analyse, compare and share outcomes. As a result, little is known about a person's full journey as they move between social and support services, general health services and mental health services, making it difficult to undertake analysis at the population level. Informed investment decisions in mental health and wellbeing programs and supports are limited by the system's ability to identify outcomes and evaluate the effectiveness of policy and services.



## Early intervention

- **Increase investment in early intervention and prevention.** Across government services, a shift of focus is required, investment in mental health services is focussed at the acute care end of the spectrum and there is comparatively lower investment in early intervention and prevention. The lifetime costs for the individual, community and government of not responding appropriately to issues as they emerge are well documented.<sup>30</sup> Service demands and pressure on the mental health system will increase as the population grows and challenges such as increasing incidence of mental health issues, co-existing ill health and disability, and an ageing population become apparent and increase demand for health and social care services.

### Justice system

- **Develop a clear implementation plan for actions to improve the response of the criminal justice system to people with mental health issues.** Barriers to reducing contact with the criminal justice system for people with mental illness and the path forward is detailed in *Towards a Just System*. This report released by the NSW Mental Health Commission in 2017<sup>31</sup> notes that "many previous reports have identified opportunities for improving the criminal justice system's response to people with mental illness and cognitive impairments, but action has been slow and fragmented." "The way forward requires:

<sup>28</sup> National Mental Health Commission 2014. *Contributing Lives, Thriving Communities. National Review of Mental Health Programmes and Services* – 30 November 2014 – Volume 1 – Attachment B page 10

<sup>29</sup> Harris, M.G., Hobbs, M.J., Burgess, P.M. et al. 2015 Frequency and quality of mental health treatment for affective and anxiety disorders among Australian adults. *Medical Journal of Australia*, cited in Jorm, A. 2015. The quality gap in mental health treatment in Australia. *Australian and New Zealand Journal of Psychiatry* 49(10).

<sup>30</sup> See for example, the Life Lifecourse Institutional Costs of Homelessness for Vulnerable Groups Project, <https://www.mhdcd.unsw.edu.au/mhdcd-projects-studies.html>

<sup>31</sup> Mental Health Commission of NSW (2017). *Towards a just system: mental illness and cognitive impairment in the criminal justice system*. Sydney, Mental Health Commission of NSW.

- recognising that many vulnerable people are not getting the help they need within the current health, disability and criminal justice frameworks
  - bringing together key proposals from past reports to create a single, coherent roadmap for NSW to achieve positive change
  - setting out a transparent pathway for reform, with clear allocation of responsibilities and a timeframe for implementation.”
- **Ensure that recommendations to improve the criminal justice system prioritise reducing the over-representation of Aboriginal people.** Aboriginal people with mental and cognitive impairments are overrepresented in the criminal justice system. A 2015 study found that contact with other government systems starts early in life: “Indigenous people in the cohort were significantly more likely to: have been in out-of-home-care, to come into contact with police at a younger age and at a higher rate as a victim and offender, to have higher numbers and rates of convictions, more episodes of remand, and higher rates of homelessness than non-Indigenous people.” This study also found that barriers to reducing this over-representation include discrimination and stigma; little recognition of trauma; normalisation of disadvantage, disability and offending; and few positive health and wellbeing options.<sup>32</sup>

### Suicide prevention

- **Continue roll-out and investment in suicide prevention initiatives and compassionate responses and build in evaluation.** The Australian Bureau of Statistics (ABS) reported that 880 people in NSW died by suicide in 2017, an increase of 9.3 per cent on 2016. This was an increase of 75 deaths in just one year, and 260 more deaths than recorded in 2008.<sup>33</sup> Investment in suicide prevention programs has been increased in recent years at the state and Commonwealth levels. Ensuring optimum outcomes for the psychological wellbeing of people and communities, and to reduce suicide, is not only an economic imperative, but a social imperative. Each life lost is a lost opportunity to lead a contributing life. Addressing the social determinants of psychological distress and mental health issues is crucial to a national suicide prevention strategy.
- Youth suicide and suicidal behaviour remains a significant issue. In 2017, 106 young people aged 15–24 years lost their lives to suicide in NSW<sup>34</sup> while in 2016–17 more than 3,500 were hospitalised due to intentional self-harm.<sup>35</sup> The impact across the domains of life of young people following attempted suicide or serious self-harm and their families who become carers/minders is significant.



### Mental health gateway services

- **Improve ‘no-wrong door’ responses.** Gateways into services and supports are crucial to intervene early and avoid deterioration of illness, distress or in living circumstances. Gateways are required across the domains of health and the domains of life.
- **Equip services to better respond to the physical health needs of people with mental health issues.** People with psychosis die between 14 and 23 years earlier than the general population. People with mental health issues experience significant physical health problems and develop preventable conditions at a much earlier age; they have poorer physical health, yet they receive less and lower quality health care than the rest of the population.<sup>36</sup>

<sup>32</sup> Baldry, E., McCausland, R., Dowse, L., and McIntyre, E., 2015. *A predictable and preventable path: Aboriginal people with mental and cognitive disabilities in the criminal justice system*. UNSW, Sydney. <https://www.mhdcd.unsw.edu.au/>

<sup>33</sup> Australian Bureau of Statistics. 2018. *Causes of death, Australia, 2017*. Cat:3303.0.

<sup>34</sup> Australian Bureau of Statistics (2018) *Causes of Death* collection, New South Wales, Cat: 3303.0 (Table 2.3).

<sup>35</sup> Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health. Available at: [www.healthstats.nsw.gov.au](http://www.healthstats.nsw.gov.au). Accessed 26 September 2018

<sup>36</sup> National Mental Health Commission, *Equally Well* - <http://www.mentalhealthcommission.gov.au/our-work/equally-well.aspx>



## A skilled and effective workforce

- **Plan for and invest in a workforce fit for the reform vision.** For system productivity improvements, the training, mix and capabilities of a future mental health and social support workforce needs investment and well considered realignment. In the absence of a national mental health and social support workforce strategy, a comprehensive and strategic approach to enable mental health practice and service reforms will be limited.
- A skilled and effective workforce for a mental health and support system requires:
  - growth to meet existing shortfalls in particular specialty areas and geographic regions;
  - training to improve competencies and capabilities to provide interventions in acute settings which are trauma informed, reduce and eliminate coercive practice and align to evidence-based practice;
  - investment in new and emerging workforces such as the peer workforce to establish professional status and standards;
  - systemic training and development of a community based workforce providing interventions and supports;
  - and supporting the mental health and wellbeing of the existing workforce who work with and support people with a mental health issue, across settings as diverse as Emergency Departments, inpatient units, the criminal justice system, Ambulance, Police, social services, Education, GPs and home care etc.

### *The workforce that delivers supports and services in support of people with lived experience*

- **Identify and fill gaps in workforce capacity and capability.** Recent reviews<sup>37 38</sup> have identified the need for targeted training and support to improve the mental health workforce capability and culture to increase patient and client safety and outcomes.
  - Workforce shortages in areas such as psychiatry, nursing, psychology and social work have already been identified, and are particularly severe in rural and remote areas.<sup>39</sup> Under resourced mental health workforces impact poor recovery.
  - There is significant under resourcing in the acute and community mental health workforce. Stress and burnout of the current inpatient mental health workforce significantly impacts productivity. The trauma experienced by this workforce is significant and needs to be acknowledged. The level of complexity and acuity of the mental health needs of patients means allied health staff in particular are often drawn in to crisis assessments and management and are not operating in the full skill set that could benefit a person, for example: providing physical health care; making connections to employment, housing and social networks.

### *The general workforce*

- **Improve integration of mental health and employment supports.** Mental health issues are associated with reduced participation in the labour force, reduced productivity in the workplace, and increased rates of absence. There is a lack of integration between rehabilitation and return to work programs. Models of rehabilitation and return to work are not currently built on outcomes.

<sup>37</sup> Wright, M., Crowe, J., Huckshorn, K., Lenihan, K., Mooney, J. and Shields, R. 2017. *Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities*. Available from

<https://www.health.nsw.gov.au/mentalhealth/reviews/seclusionprevention/Documents/report-seclusion-restraint-observation.pdf>

<sup>38</sup> Royal Commission into Institutional Responses to Child Sexual Abuse. 2017. <https://www.childabuseroyalcommission.gov.au/final-report>

<sup>39</sup> Hosie, A., G. Vogj, J. Hoddinott and Y. Comeau (2014). *Crossroads: rethinking the Australian mental health system*. Sydney, Inspire Foundation.



- **Address the barriers that prevent social and/or economic participation of carers.** Family members and carers have lower workforce participation.<sup>40</sup> This contributes to substantial savings in social care, but often has negative effects on the health and wellbeing of those providing that care. Systems of supports that provide respite care, housing and daily living supports for the person with lived experience together with early intervention options in the community are enablers of improved mental health of carers and opportunities to participate in their communities, workplaces or social networks.
- Carers need care and support themselves to participate and lead contributing lives. We know that:
  - carers and their families experience high rates of mental health problems, significantly worse mental health and vitality, and higher rates of depression than the general population<sup>41</sup>
  - carers are more likely to be in poor physical health than the general population<sup>42</sup>
  - many carers cease working once they become a carer because of the responsibilities the role entails, and a large number of these carers want to be in paid employment<sup>43</sup>
  - more than a third of carers who are employed are concerned about losing their job<sup>44</sup>
  - almost half of carers' families do not use support services.<sup>45</sup>

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<sup>40</sup> "For those aged 15 to 64 years, the labour force participation rate for primary carers (56.3 per cent) and other carers (77.2 per cent) was lower than that for non-carers (80.3 per cent)." Australian Bureau of Statistics. 2016. *Disability, Ageing and Carers, Australia: Summary of Findings, 2015*, cat: 4430.0

<sup>41</sup> Edwards, B., D. Higgins, M. Gray, N. Zmijewski and M. Kingston (2008). *The nature and impact of caring for family members with a disability in Australia*. Canberra, Australian Institute of Family Studies.

<sup>42</sup> Ibid.

<sup>43</sup> Ibid.

<sup>44</sup> Cummins, R., J. Hughes, A. Tomy, A. Gibson, J. Woerner and L. Lai (2007). *The wellbeing of Australians: Carer health and wellbeing*. Geelong, Deakin University, Australian Unity, Carers Australia.

<sup>45</sup> Edwards, B., D. Higgins, M. Gray, N. Zmijewski and M. Kingston (2008). *The nature and impact of caring for family members with a disability in Australia*. Canberra, Australian Institute of Family Studies.

## 2c) Shifting the focus to what works – core elements of system change



### Participation, influence and leadership of people with lived experience

- **Implement strategies such as the Lived Experience Framework.** In 2018 the Commission released the Lived Experience Framework<sup>46</sup> in response to calls from people across NSW “for our mental health and social services to be truly centred on the people who use them and supportive of their individual journeys of recovery.” Embracing that the “participation, influence and leadership of people with lived experience ... in service design, delivery, monitoring, reporting, research, evaluation and improvement activities ... will lead to better outcomes for people experiencing mental health issues and those who offer them hope and support, as well as improving the working environment of those who give professional help.”
- As articulated in the Lived Experience Framework, there are three focus areas for the actions required to achieve change: shift the usual ways of doing things, cultures and assumptions; demonstrate leadership commitment and action; and refocus policies, resources, education and employment opportunities and structures. Nine outcomes will demonstrate real change:
  1. The number of full time equivalent paid positions for people with lived experience of mental health issues and caring, families and kinship groups increase in each mental health and social service annually to optimal levels.
  2. Designated roles of people with lived experience of mental health issues and caring, families and kinship groups are identified across all levels in mental health and social services.
  3. Service accreditation processes demonstrate that they meet or exceed standards for lived experience participation and leadership.
  4. NSW Government reports and publicly releases data to demonstrate increases in and impacts of projects co-designed with people with lived experience of mental health issues and caring, families and kinship groups.
  5. Paid participation policies have been developed and implemented in all mental health and social services.
  6. Lived experience participation is formalised in policy of all government and nongovernment mental health and social services.
  7. All public mental health services meet National Safety and Quality Health Service Standard 2: Partnering with Consumers.
  8. All mental health programs and services demonstrate they are implementing A National Framework for Recovery Oriented Mental Health Services.
  9. Nongovernment organisations adopt suitable recovery oriented tools to reflect the recovery focus of their service.

<sup>46</sup> Mental Health Commission of NSW. 2018. *Lived Experience Framework for NSW*. [nswmentalhealthcommission.com.au](http://nswmentalhealthcommission.com.au)

- **Make sure people have the opportunity to participate in their own care and treatment.** This is an essential element of participation, influence and leadership. For some people options such as supported decision-making and advance care directives will be useful to enable this. Teamwork between clinicians and families and carers is an area that needs further effort, with international models such as the Triangle of Care being well established practice examples.<sup>47</sup> The 2010 guide to The Triangle of Care was developed in the UK jointly by the Carers Trust and the National Mental Health Development Unit. The Guide emphasises the need for better local strategic involvement of carers and families in the care planning and treatment of people with mental health issues.
- **Build on good examples of lived experience participation, influence and leadership.** There are good examples of lived experience leadership, participation and influence. Participants in an April 2019 roundtable with the Productivity Commissioners identified some of these including peer operated services, local Consumer Advisory Committees and co-design projects, board roles for people with lived experience, patients leading their own clinical reviews, clubhouses, and hearing voices groups. Levers such as legislation and funding models can be used to good effect. The *Mental Health Commission Act 2012* requires that “the Commissioner or at least one Deputy Commissioner must be a person who has or has had a mental illness.” Funding for the Personal Helpers and Mentors Program required that a proportion of employees be people with lived experience.
  - There are emerging examples of consumer-led research units in universities in Australia and internationally and the value this provides, including by identifying research priorities that are important to people with lived experience, is starting to be documented in the literature.<sup>48 49 50 51</sup>

However, examples of good practice are still isolated and significant capability building is required in all parts of the system to embed this way of working.



## Integration and coordination

- **Ensure a holistic approach through improved service integration and coordination.** This requires horizontal and vertical integration of health and other social service systems to support people living with mental health issues.
- **Establish regional partnerships.** Coordination and integration between planners and funders (including processes for distribution of funding at regional levels) is critical to supporting improved integration and coordination at the service delivery level. Mechanisms and structures that are established to support joint planning, funding and monitoring (as discussed earlier in this document) should translate to the service delivery level to further strengthen integration and coordination.
- **Develop pathways to support coordination and continuity.** Attention needs to be paid to collaboratively developing care pathways where the purpose of each element is transparent and the transitions along the pathway are managed to reduce duplication and ensure continuity. Pathways should be agnostic of service provider and setting. Co-production and shared protocols developed with people with lived experience between agencies are examples of moving towards improved coordination.

<sup>47</sup> <https://professionals.carers.org/working-mental-health-carers/triangle-care-mental-health>

<sup>48</sup> Rose, D. 2015. The contemporary state of service-user-led research. *The Lancet*. Vol 2. November 2015

<sup>49</sup> Banfield, M. Morse, A.R., Gulliver, K., Edwards, B., Simon, N., Langley, E., Rees, H., Wells, A., Tyson, P.J., Thomas, P., Meudell, A., Kitt, F., Mitchell, B., Bowen, A., & Celia, J. 2018. Mental Health Research priorities in Australia: a consumer and carer agenda. *Health Research Policy and Systems*. 16, 119.

<sup>50</sup> Gill, K. 2017. Creating an environment that cultivates meaningful consumer-led or co-produced research. Are we there yet? *New Paradigm*, Summer 2017/18.

<sup>51</sup> Ghisoni, M. Wilson, C.A., Morgan, K., Edwards, B., Simon, N., Langley, E., Rees, H., Wells, A., Tyson, P.J., Thomas, P., Meudell, A., Kitt, F., Mitchell, B., Bowen, A., & Celia, J. 2017. Priority setting in research: user led mental health research. *Research Involvement and Engagement* 3:4.

- **Strengthen community based mental health services.** The imperative is to strengthen community based models of care that ensure the system has strong, integrated and effective responses to people's needs across the whole continuum of care. This requires an expansion of services to support people with mental health issues to live in the community, without the need for hospital based care when it could be avoided through earlier intervention or community based options.
- **Implement stepped care models.** Future priorities point towards an increased investment in Stepped Care Models where supports can be increased or decreased as required by the person's mental health and wellbeing needs. These need to be scaled up and evaluated.
- **Enhance communication and information.** Information must flow with people regardless of which services they are seeking. This requires the development of pathways, clear communication between service providers, and clear information for people with mental health issues and their families and carers, to assist them when they move between services. Electronic medical records support improved communication and sharing of information between health care providers. Perceived barriers to legally sanctioned information sharing must be overcome.

Improved communication and integrated high quality mental health care is supported by several initiatives such as electronic medical records (eMR) eMR Connect and HealtheNet which connects health information about a person including their national My Health Record if they have one.

- **Improve mental health literacy of the workforce and people with lived experience of mental health issues and caring.** Through improved health literacy, people can and are supported to participate in shared decision making and are empowered to access information and self-manage their overall health and social care. Health literacy approaches have the potential to improve the use by people with lived experience of available tailored stepped care service options that can improve their physical and mental health as early in a course of illness as possible. Likewise, improving the mental and physical health literacy of the workforce would improve engagement with clients about their overall health issues.
  - Funded through the Commonwealth Innovation Fund, NSW (via the Mental Health Commission) is embarking on a 3 year mental health literacy project. This project will assist PHNs and LHDs to organise their services and tailor communication about stepped care options in a way that helps people living with mental health issues and their families and carers know what they need, where to get it and how to engage with it. The project also assists clinicians and services to better understand mental health and physical health and the interplay between both, to tailor communication and build the confidence and capability of clients to engage with the care they need or request.
- **Continue investment in information and communications technology infrastructure** This is required to increase quality and accessibility to consumer data across multiple platforms. There is an increased use of technologies that allow more seamless and accessible care to be delivered. This may involve remote monitoring, delivery by a single provider or multidisciplinary team or case conferencing between providers.
- **Implement initiatives to support housing stability and prevent homelessness** These initiatives are critical to support recovery and must be guided by the preferences of people living with mental health issues. There is a particular need to build on temporary crisis accommodation services by delivering effective prevention and early intervention strategies. Addressing mental health issues and housing needs before they escalate into crises will generate cost efficiencies for government and huge improvements in quality of life for many people with mental illness.

- The Housing and Accommodation Support Initiative<sup>52</sup> (HASI) supports people who experience mental health issues to live independently and sustainably in the community in a range of tenure types. It is a proven model for homelessness prevention that merits expansion across new client groups. An evaluation found about half of the HASI participants had access to secure accommodation at the time they were accepted into it. Ninety per cent had not ended a tenancy since joining it. Of those that ended theirs, 86 per cent were for planned reasons such as moving to more appropriate or other long-term housing.<sup>53</sup>
- Many other government initiatives seek to address the housing needs of people living with mental health issues including: Pathways to Community Living Initiative<sup>54</sup> (NSW Health initiative supporting people who have been in hospital long term transition to community living); Early intervention tenancy support service<sup>55</sup>; Their Futures Matters<sup>56</sup> (NSW Department of Family and Community Services [FACS] initiative identifying early intervention for people in social housing); and Way to Home.<sup>57</sup> Evidence is also presented in *Housing, homelessness and mental health: towards systems change*<sup>58</sup> and *Mental health supported accommodation services: a systematic review of mental health and psychosocial outcomes*<sup>59</sup>.
- **Employ peer workers in housing services**<sup>60 61 62</sup> – the housing sector is an example of an additional setting where peer workers could be trialed.
- **Provide greater advocacy support for people living with a psychosocial disability accessing the NDIS.** Advocating on behalf of long stay mental health patients and those with complex needs for NDIA planners who may be more skilled in these areas has been shown to make a significant difference.
  - In the South Western Sydney LHD, a dedicated mental health lead for NDIS has been established by the LHD and a dedicated mental health planner has been established locally by the NDIA. The close working arrangement between these two positions is reported as a critical success factor.



### Effectiveness of services

- **Enhance recovery oriented mental health services that are centred on and adapt to people's aspirations and needs.** It requires a shared vision and integration across partner organisations and is sustained by a diverse and appropriately supported and resourced workforce that includes people with lived experience of mental health issues. Recovery oriented practice enables people with lived experience to lead their own recovery and wellbeing and define their goals, wishes and aspirations to lead the productive life of their choosing.

<sup>52</sup> <https://www.health.nsw.gov.au/mentalhealth/Pages/services-hasi-cls.aspx>

<sup>53</sup> McDermott, S., J. Bruce, I. Oprea, K. R. Fisher and K. Muir (2011). *Evaluation of the Mental Health, Housing and Accommodation Support Initiative (HASI): Second Report*, Social Policy Research Centre, University of New South Wales.

<sup>54</sup> <https://www.health.nsw.gov.au/mentalhealth/services/pages/pathways-community-living.aspx>

<sup>55</sup> <https://www.missionaustralia.com.au/servicedirectory/191-housing-homelessness/early-intervention-and-tenancy-support-service-south-west-sydney>

<sup>56</sup> <https://www.theirfuturesmatter.nsw.gov.au/>

<sup>57</sup> <https://www.cityofsydney.nsw.gov.au/community/community-support/homelessness/way2home>

<sup>58</sup> Brackertz, N., Wilkinson, A., Davison, J. 2018. Housing, homelessness and mental health: towards systems change. AHURI.

[https://www.ahuri.edu.au/\\_data/assets/pdf\\_file/0023/29381/Housing-homelessness-and-mental-health-towards-systems-change.pdf](https://www.ahuri.edu.au/_data/assets/pdf_file/0023/29381/Housing-homelessness-and-mental-health-towards-systems-change.pdf)

<sup>59</sup> McPerhson, P., Krotofil, J. & Killaspy, H. 2018. *Mental health supported accommodation services: a systematic review of mental health and psychosocial outcomes*. BMC Psychiatry. 2018; 18: 128.

- **Explore data linkage initiatives.** Data linkage has the potential to underpin and inform transformational change of the system. Data linkage addresses a major gap in understanding a person’s journey and provides a holistic picture of the services received and care delivered.
  - The Mental Health Services-Census Data Integration project<sup>63</sup> has greatly increased the power of the data to support analysis of the circumstances and characteristics of people experiencing mental health issues as they use services provided through the health system. This data resource can assist in the development and evaluation of mental health programs and support services, and for example in analysis of the relationship between mental health-related services, medication use, and key socio-economic information such as education, employment and housing. Given the unique data and person centred opportunities for analysis, a second data project linking the 2016 census with the mental health administrative data would be highly valuable for understanding participation and productivity.
- **Measure consumer experiences.** The voice of lived experience provides the most critical lens through which the effectiveness of services is assessed. The Your Experience of Service (YES) provides a measure of client/consumer experiences of care that is being used to support quality improvement, service evaluation and benchmarking of services. This survey is being expanded and will provide a picture of experiences across the public, CMO and primary care sectors. Carer experiences in public and CMOs services will also be included in the future.
- **Establish an evaluation register.** A central evaluation register is recommended to identify all research and evaluation projects commissioned or conducted by agencies and organisations where mental health is key outcome. The objective would be to increase transparency and accountability and implement a level of independence around evaluation. The management of any evaluation register would need to be independent, this may be managed for example by the state mental health commissions or similar and would inform strategic investment decision making. A central register for evaluations would also support the sharing of outcomes and lessons learned and provide an evidence base to support planning, funding and implementation of programs that are efficient and effective.



## Early intervention

- **Strengthen the focus on early intervention and implement programs in a comprehensive manner.** This will reduce pressure on acute services and income support. A strong community mental health system will support early intervention and enable people to live productive lives in their community connected to their social and support networks, culture and families, carers and kinship groups. There are a number of early intervention services and initiatives for children and young people involving Commonwealth, state and community managed organisations. There is good evidence of the effectiveness of many of these, such as school based social and emotional learning programs.<sup>64</sup> The Got It!<sup>65</sup> And School-Link program are examples of evidence-based programs in NSW.
- **Shift the focus towards prevention.** This would include building key partnerships across government agencies, local health networks and community managed organisations – in family and community services, education, housing and health – to prioritise early childhood mental health and wellbeing and reduce trauma in young lives. It would also mean collaborating to develop mental illness prevention strategies, to support wellbeing and mental health for people of all ages in workplaces, communities and other settings.

<sup>64</sup> Christensen, H., A. Calear, R. Tait, J. Gosling, K. Griffiths and K. Murray (2011). *School based intervention programs and shared care collaborative models targeting the prevention of or early intervention in child and adolescent mental health problems: a rapid review*. Sydney, NSW Ministry of Health.

<sup>65</sup> Debbie Plath Consulting & Family Action Centre, The University of Newcastle. 2014. *Got It! Final Evaluation Report*. Available at <https://www.hsnet.nsw.gov.au/system/files/attachments/881230315143304FINAL%20Got%20It%21%20AUGUST%202014%20AED%20Revised%20Report.pdf>

### Early intervention in the criminal justice system

- **Targeting ‘at risk’ population groups.** As reported in *Towards a Just System*, “early neglect, abuse and trauma are common experiences among people who become entrenched in the criminal justice system. ... These early childhood interactions with support services present a key opportunity to identify impairments and to provide the supports these children need to deal with their challenging life circumstances.”<sup>66</sup>
- **Increase access to diversion.** This is also a central plank of the reform program recommended in *Towards a Just System*. When people have fallen through the gaps of earlier programs and approaches, diversion can be used as an opportunity to change the trajectory of a person’s life.
- **Reorient youth justice towards a more therapeutic approach to divert young people who have been convicted away from reoffending as adults.** A significant majority of young people in custody have mental or cognitive impairments. Intensive intervention needs to be provided early in their contact with the criminal justice system – such as when they first come to Police attention or are made the subject of an apprehended violence order.

### Suicide and self harm prevention

- **Implement strategies such as the NSW Suicide Prevention Framework .**<sup>67</sup> The NSW Government and key partners are to develop a suite of resources to support implementation of the Framework across five priority areas: 1. Building individual and community resilience and wellbeing; 2. Strengthening the community response to suicide and suicidal behaviour; 3. Supporting excellence in clinical services and care; 4. Promoting a collaborative, coordinated and integrated approach; 5. Innovating for a stronger evidence base.
- **Empower community responses.** Support for communities to drive credible action and lead solutions is required. Whole of community activity is required to address the social determinants that impact on a person’s ability to continue to hope. This will involve building community resilience and wellbeing and supporting community led suicide prevention actions in response to challenges as well as reducing stigma, increasing help seeking, and creating safe community conversations. Priority populations may include, but are not limited to, young people, Aboriginal communities, and LGBTIQ+ people.
- **Enable multi-agency responses.** These are required as the foundation of community responses to address the social determinants of suicide and support communities of hope and resilience.
  - Aftercare projects are being rapidly expanded throughout NSW. NSW Health is funding eight community managed organisations to deliver community based suicide prevention activities across NSW under the four year Suicide Prevention Fund. From 2016–17 to 2019–20, these projects are aimed at developing local responses to local needs.<sup>68</sup>
- **Monitor and evaluate the systems approach to suicide prevention.** This approach has been a major driver to increase and refocus suicide prevention efforts in Australia. It will be important to understand the impact this has had on numbers of deaths from suicide over time.

### Social inclusion and public mental health

- **Invest in social participation and inclusion.** Social prescribing is one example to increase social participation and inclusion, this can include referral: for social activity; to information or guidance; to a community group; or to learning and skills. Emerging evidence is promising.<sup>69</sup>
  - The icare Foundation is funding a social prescribing trial working with primary and other healthcare providers across NSW “prescribing” nonmedical interventions, like social activities.

<sup>66</sup> Mental Health Commission of NSW (2017). *Towards a just system: mental illness and cognitive impairment in the criminal justice system*. Sydney, Mental Health Commission of NSW.

<sup>67</sup> Mental Health Commission of NSW (2018). *Strategic Framework for Suicide Prevention in NSW 2018–2023*.

<sup>68</sup> <https://www.health.nsw.gov.au/mentalhealth/Pages/funding.aspx>

<sup>69</sup> See a summary here <https://www.kingsfund.org.uk/publications/social-prescribing>

- **Build community resilience and wellbeing.** Mental health and wellbeing are fundamental to a strong, functional and resilient society which we, as individuals, make up. The resilience that comes from good mental health and wellbeing is the foundation for safer and healthier families, schools, workplaces and communities; higher educational achievement and improved relationships and personal dignity.<sup>70 71</sup>

### Addressing stigma and discrimination

- **Use evidence to invest in programs that will reduce experiences of stigma and discrimination.** Making a real difference to people's experience of stigma and discrimination will have flow on effects on willingness to seek help, on the quality of that help, and on inclusion in workplaces and the community.
  - Stigma and discrimination was discussed at the April 2019 roundtable with the Productivity Commissioners. Participants pointed to the evidence on the power of one to one contact as a mechanism for breaking down stigma and the need to create safe places to tell their own stories. They also thought that education on the legal prohibitions against discrimination on the basis of disability would be helpful. Designated lived experience positions across all social services would assist in breaking down stigma and discrimination within services. Any campaigns attempting to address stigma should present the diversity of people with lived experience. There is good research that can be drawn on to make recommendations about investment in anti-stigma initiatives.<sup>72 73 74</sup>



### Mental health gateway services

- **Ensure a 'no wrong door approach'.** A 'no wrong door' approach is essential for people living with mental health issues and their carers to ensure timely access to the services and supports they need, and in turn, to avoid escalation of issues to crisis point.
  - Offering **holistic and comprehensive assessment of needs** at multiple contact points for people living with mental health issues, this should occur at typical entry points to mental health including general practice visits, community managed organisations, social services and public mental health services. Clinicians undertaking holistic health assessments are best placed to make 'warm' referrals to other relevant mental health, health and social services.
  - Service providers need to **work together** in an integrated way to support the needs of people with mental health issues. Simply layering care coordinators or navigators for people with mental health issues on top of an existing system is unlikely to be beneficial.
  - Using new **digital options** and information technology infrastructure to support access to services for people living with mental health issues, and service effectiveness and efficiency. ICT advancements facilitate the speedy and convenient delivery of mental health information and support. At times navigating the vast range of available resources can be overwhelming. Online resources and supports form an important component of a no wrong door approach.

<sup>70</sup> World Health Organisation (2004). *Promoting mental health: Concepts, emerging evidence, practice: Summary report*. Geneva, World Health Organization.

<sup>71</sup> Moodie, R. and R. Jenkins (2005). "I'm from the government and you want me to invest in mental health promotion. Well why should I?" *Promotion & Education*: 37-41.

<sup>72</sup> Reavley, N., Too, T. & Zhao, M. 2015. *National Surveys of Mental Health Literacy and Stigma and National Survey of Discrimination and Positive Treatment: A report for the Mental Health Commission of NSW*. Available at

<https://nswmentalhealthcommission.com.au/sites/default/files/Report%20-%20National%20Surveys%20of%20Mental%20Health%20Literacy%2C%20Stigma%20and%20Discrimination%20-%20NSW%20findings.pdf>

<sup>73</sup> Mental Health Commission of NSW. 2017. *Stigma and discrimination in NSW. A summary of NSW findings from the National Surveys of Mental Health Literacy and Stigma and National Survey of Discrimination and Positive Treatment*. Available at

<https://nswmentalhealthcommission.com.au/sites/default/files/Report%20-%20Summary%20of%20University%20of%20Melbourne%20report%20on%20NSW%20findings%20for%20National%20Surveys.pdf>

<sup>74</sup> Beyondblue. 2015. *Information Paper - Stigma and discrimination associated with depression and anxiety*. Available at

[https://www.beyondblue.org.au/docs/default-source/policy-submissions/stigma-and-discrimination-associated-with-depression-and-anxiety.pdf?sfvrsn=92367eea\\_2](https://www.beyondblue.org.au/docs/default-source/policy-submissions/stigma-and-discrimination-associated-with-depression-and-anxiety.pdf?sfvrsn=92367eea_2)

- Western Sydney Local Health District (LHD) has implemented The No Wrong Door **Mental Health Charter**,<sup>75</sup> a collective commitment of organisations in South Western Sydney to an overarching No Wrong Door approach built around recovery oriented practice.



### A skilled and effective workforce

#### *The workforce that delivers supports and services in support of people with lived experience*

- **Utilise workforce data and evidence-based tools to inform workforce requirements.** Ensuring adequate workforce capacity, capability and distribution to meet changing population needs is essential, particularly for children and adolescents and older people where the workforce gaps are greater. Additionally, improving subspecialty workforce data collections including peer workforce data and Aboriginal mental health worker data will further inform service requirements.
- **Fund and increase access to allied health** Enhanced access by people with lived experience to allied health professionals particularly speech pathologists, dietitians, exercise physiologists, physiotherapists, occupational therapists and pharmacists is required. Such access contributes to improved recovery and physical health, physical and emotional wellbeing and social participation and inclusion.
- **Continue to build a capable and compassionate workforce.** There is a need for targeted, capability based training that can be readily accessed by workforce groups. Increasing the capability of the workforce to work with new and emerging technologies is also an important focus. In addition to training, it is important for all staff to be able to access appropriate levels of supervision, mentoring, coaching, professional development opportunities and other support required in their role. Sufficient staffing levels across all disciplines will further enable the workforce to deliver individualised, respectful and recovery oriented and trauma informed care.
- **Invest in new workforce roles** - NSW is enhancing peer worker and Aboriginal mental health worker positions in mental health services. These roles strengthen multidisciplinary teams. Investment and expansion of these two groups needs to be a priority to deliver improved outcomes across communities and services. There are also opportunities to strengthen the workforce through emerging roles such as allied health assistants in mental health and Liaison Consultation Psychiatry.
  - The Djirruwang Aboriginal and Torres Strait Islander Mental Health Worker Education and Training Program (The Djirruwang Program) is an example of an important piece of infrastructure for supporting the building of new mental health workforces. The program has established a a clinical based tertiary level mental health course in Australia designed for Indigenous people, currently rolled out by Charles Sturt University. The program has been evaluated several times.<sup>76</sup>
  - Peer worker roles are integral to recovery and embedding lived experience at all levels – including peer support to consumers and carers, peer mentoring, peer leadership, policy development and research. People with lived experience of mental health issues should be part of all workforces that deliver services to client groups with a significant number of people who experience mental health issues. Further action is required to build a supportive infrastructure to ensure the peer workforce is embedded in the culture of service delivery to people who experience mental health issues. Services and agencies need to consider how to attract a mix of peer leaders and new staff, create support structures, develop career pathways and support training and development specific to this workforce. Carer Peer Workers have the personal experience of providing support and care for a person with lived experience. They use their experience as a carer together with skills, experience and qualifications and are employed to support the families, carers and support people of consumers who are on a recovery journey.

<sup>75</sup> <https://nowrongdoor.org.au/mental-health-charter/>

<sup>76</sup> See a summary of the program in Brideson, T., Havelka, J., McMillan, F., & Kanowski, L. 2014. The Djirruwang Program: Cultural Affirmation for Effective Mental Health in Dudgeon, P., Milroy, H., & Walker, R. *Working Together. Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice.*

- There is a steadily growing number of research studies showing that services controlled and run by people with lived experience of mental illness are effective in supporting recovery. These are characterised by consumer control, choice, voluntary participation and opportunities for person led decision making.<sup>77</sup>
- **Work with and build capacity in partner workforces.** Working with the workforces of CMOs, education, aged care and disability providers is an opportunity to improve services for people with lived experience. New partners include PHNs and NDIS providers, a range of private, public, philanthropic and other service providers and funders not previously engaged.
- **Build a positive workplace culture and reduce discrimination.** Valuing the knowledge, skill and contribution of the mental health workforce will support working relationships with other health professionals and the overall wellbeing of the workforce. A culture of collaboration and integration leads to the breaking down of ‘traditional silos’ and ultimately shared ownership for person centred care and decision making. This in turn reduces discrimination against people with mental health issues presenting to services.
  - A positive workplace culture can support the mental health of staff, increase productivity and reduce absenteeism. Additionally, attracting and retaining people with lived experience in the workforce also attracts and retains, expertise, corporate knowledge and experience. It is good business sense to do so. It also provides economic stability, purpose and inclusion for people and in turn supports their recovery.
- **Provide support for carers.** Supporting carers to remain in the workforce or return to the workforce, remain engaged in the community, and stay healthy while continuing their caring role are essential. In assessing a person’s family and carer circumstances, advice is always provided about where to find more information and support for family members and carers, and that where required, assistance is provided in accessing these. This will include access to respite care, Centrelink benefits and return-to-work programs for carers, and information and advice on family and carer support groups

### *Mentally healthy workplaces*

- **Support good mental health and wellbeing in the workplace.** Mental ill health and its cost to employees is well documented. Consistent with previous reports, evidence-based selective and indicated prevention (workplace health promotion and CBT based stress management) and psychological focussed return to work programs, produce a positive return on investment of between \$1.5 and \$4 for every dollar spent, even just using these basic costs.<sup>78</sup>
  - SafeWork NSW is leading the implementation of the Mentally Healthy Workplaces in NSW Strategy 2018–2022, which is aimed at improving workplace mental health. Creating mentally healthy workplaces is a shared responsibility of employers and workers. Best practice workplaces are a positive environment that improves people’s mental health. Mentally Healthy Workplace initiatives encourage prevention of mental ill health or illness by assessing the workplace and work practices for risk factors in consultation with their workers. Mentally healthy workplaces will also consider mitigating factors for all workers to be able to connect workers with early support and assist their recovery at work.
  - The Mental Health Commission of Canada has developed three education programs designed to address and promote mental health and reduce the stigma of mental illness: Working Mind for First Responders; Working Mind for civilian population, and the Inquiring Mind for an educational / student setting, in a first responder setting and, in a workplace, setting respectively. The programs were developed by clinicians and peers and based on scientific research and best practices.<sup>79</sup>
  - The Commission supports the recommendation of the recent review of model WHS laws that regulations should be made dealing with psychological health.

<sup>77</sup> Grey F and O’Hagan M. 2016. *The effectiveness of services led or run by consumers in mental health: rapid review of evidence for recovery-oriented outcomes*: an Evidence Check rapid review brokered by the Sax Institute ([www.saxinstitute.org.au](http://www.saxinstitute.org.au)) for the Mental Health Commission of New South Wales.

<sup>78</sup> Yu, S and Glozier, N. 2017. *Mentally healthy workplaces A return-on-investment study* August. Centre for Health Economics Research and Evaluation (CHERE), University of Technology Sydney and Brain and Mind Centre, The University of Sydney

<sup>79</sup> <https://theworkingmind.ca/about-us>

## Employment support

- **Reduce barriers and implement the evidence in helping people with lived experience including carers into work, but retain and expand choice.** The evidence on effective supports and associated returns for assisting people with mental health issues into employment are well documented and the Productivity Commission is strongly encouraged to consider this evidence.<sup>80 81</sup> The Productivity Commission is also directed to the reviews of Disability Employment Services (DES) and the NSW Commission's contribution to this review.<sup>82</sup> Also the NSW Commission points the Productivity Commission to the submission made by Flourish Australia especially in regard to the section summarising its analysis of the disincentives (and deterrents) of the DES for employers and employees alike.

- Most policy discussion and evidence reviews focus on the obtaining and maintaining competitive employment. The Commission supports a policy goal of the elimination of all barriers to safe and acceptable employment in competitive settings for all people with mental health issues. At an April 2019 roundtable with the Productivity Commissioners people named these barriers as discrimination and stigma, lack of reasonable adjustments and understanding of psychological accessibility requirements, effects of medication, inflexibility of the DSP, transport, and lack of supportive education settings.
- Given these barriers, particularly those related to employers, the achievement of open and competitive employment for all is currently aspirational. In the meantime, choice must be an important principle that accompanies a goal of zero barriers to competitive employment. For some people with mental health issues transitional employment models such as social enterprise will be a meaningful choice and excellence in such models should be pursued, including through research which is currently limited. Employment outcomes should also be reviewed alongside other outcomes such as quality of life and person directed indicators to ensure a holistic picture of outcomes is provided.
- At the April 2019 roundtable participants listed a variety of approaches to economic and social participation that have proved effective for them. This included access to good clinical care, support to stay in study, social support and support from peer workers, education for employers, person defined measures of success, safe and accessible community activities, support to gain skills such as driving, and skilled staff in employment services.
- Changes that would make a difference to the economic and social participation of carers was also discussed at the roundtable. The difficulty of proving that you have caring responsibilities was raised and ability to access carer leave when you may be caring for someone outside your immediate family. Wellbeing plans at work could help start conversations with managers. Services such as respite would make a significant difference to a carers ability to participate in work and social activities. It is key that other services are there to reassure carers that their loved one is being supported appropriately. Specific supports for young carers in the settings of their everyday life are also required.
- One carer made this particular observation:

*This is a challenging area and one that requires a great deal of understanding due to the complexities involved. As everyone who suffers from a mental illness or mental ill health requiring care, presents in many different ways, the impacts upon the carer and or carers can also present in many different ways. Unless one has experienced caring for someone who is in a state of acute / chronic distress/ mental illness, it is hard to comprehend what negative impacts that situation is having upon the carer's own mental health. The critical factors are willingness, openness and courage on the part of the employer / employer's representative. The positive impacts for an employer to be willing to help a carer cope with this most challenging period of their lives are immeasurable.*

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<sup>80</sup> Investing to Save. *The economic benefits for Australia of Investment in Mental health reform*. Mental Health Australia and KPMG. May 2018

<sup>81</sup> Suijkerbuijk YB, Schaafsma FG, van Mechelen JC, Ojajärvi A, Corbière M, Anema JR. Interventions for obtaining and maintaining employment in adults with severe mental illness, a network meta-analysis. *Cochrane Database of Systematic Reviews 2017, Issue 9*. Art. No.: CD011867. DOI: 10.1002/14651858.CD011867.pub2.

<sup>82</sup> [https://engage.dss.gov.au/des\\_reform\\_nov16-submissions/1481861284/](https://engage.dss.gov.au/des_reform_nov16-submissions/1481861284/)