



Samaritans

Compassion Integrity Justice



Productivity Commission Inquiry

The Social and Economic Benefits of Improving Mental Health

Prepared by Samaritans Foundation

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Executive Summary

This submission represents the collective input of key, staff which has been informed by their vast experience working with people with mental ill-health and the many intersections with our services. Central to our key messages across various sector reforms is the need for greater focus on prevention and early intervention.

The success of prevention and early intervention programs across the social sector is evident in research worldwide, and adopting policy reforms that focus on these areas will have the greatest impact and result in long term sustainable outcomes. The mental health sector is no different. Institutions such as Everymind have produced evidence-based frameworks for reducing mental ill-health through prevention and early intervention strategies (2017).

Preferences for early intervention and prevention approaches are present throughout this paper and are interwoven with the other common themes:

- The need for system reforms that enable connected service provision and wrap around supports, which requires flexibility from the system itself
- Training needs across mental health first aid, alcohol and other drugs and trauma informed care
- Identifying and addressing trauma
- Reducing stigma and improving community and employer responses

Feedback from Samaritans staff explored in this paper broadly reflect the strategies presented by Everymind (2017), as well as various other organisations and bodies. This demonstrates the commonality of these principles and themes across the sector.

Samaritans have provided an *in-confidence* case study supplementary to this paper. While the case study has been de-identified, the level of detail contained may inadvertently identify the family who provided their reflections, hence the request for confidentiality.

Systems and Supports

NDIS

Many clients with mental health issues that previously had support through day programs or case management are unable to access these under the NDIS. Further, clients that are navigating the NDIS often have no family or social support and find it difficult to complete the applications, present supporting documentation and/or meet the requirements of the NDIS (for example people experiencing homelessness have far more difficulty accessing the NDIS).

Within Samaritans ADE, supported employees mostly come to work to socialise, learn new skills and improve their financial situation. Challenges are present with NDIS employment funding for people experiencing mental health issues with a lack of consistency and unclear guidelines for funding application. Some of the participants supported by Samaritans with a mental illness diagnosis used to receive funding from Department of Social Services (DSS), however have been denied employment funding through NDIS. This is usually after the NDIA observed that the participant 'seemed to be doing well'.

For people with mental illness engaged in work through an ADE, there can often be additional needs or supports required of the employer. The support needs in this environment are much higher with a higher concentration of staff with mental illness than in an 'ordinary' workplace, however funds and additional support are not available to ADEs to meet those additional needs.

Some supported employees have no other funding types under their plans that can be used to support them to engage with other services, contact government departments such as Centrelink or the ATO, or fill out forms such as those for Housing NSW. Samaritans managers often act in this support role despite having no additional resources or funding. To combat this issue, NDIS plans might include a type of case management fee under

the NDIS employment funding model. This would enable ADEs to provide greater support to their supported employees.

Carers and informal supports

The mental health care system in Australia must dedicate supports to informal carers who often suffer their own mental health issues as a result of the level of care required for their family member. Samaritans recognise the need for multiple interventions to improve the system for informal carers, including for example:

- Providing early stage interventions for their family member that take pressure off carers and provide them with tools and resources for coping
- Introducing and supporting programs targeted at supporting carers with their own mental wellbeing
- Providing respite, access to accurate information and policy safeguards that enable them to maintain their own lifestyles and avoid impacts to their income and relationships
- Improving the system to enable collaboration and engagement as far as possible so they feel involved and remain connected to their family member
- Improve engagement with mental health professionals with knowledge of their situation that can assist them to understand their role, what they can do in certain situations and how to take care of themselves
- Provide clear referral pathways and supports to enable them to assist their family member to find suitable, secure and stable housing or access financial support.

Housing

Significant problems arise from government services such as hospitals and corrections facilities exiting people into homelessness. Better collaboration with the individual, family, health care professionals and service providers would go some way to improving this, but without the structures in place in those government services there is no accountability or responsibility.

Ideally, appropriate supports and housing would be in place prior to them being discharged.

Stable accommodation with appropriate ongoing supports are repeatedly seen to improve a persons ability to achieve their goals, contribute within community and improve self-worth.

A close relationship with Housing NSW can have many benefits for the people supported by Samaritans. Supporting the individual to have a voice and guiding them through what can be difficult, confusing or lengthy processes, often results in:

- Improved understanding by Housing NSW of the person and the barriers they are facing or issues arising from their tenancy
- Less pressure and resultant stress for the individual throughout the process

This level of collaboration and resulting outcomes vary greatly from office to office depending on the staff and resourcing at Housing NSW. Consistent practice and additional training for staff across all government departments would improve this situation.

Coordination and integration

The overarching support model for people who suffer mental ill-health should consider the integrations and connections between all services.

The system to support people experiencing mental health issues must enable and empower the many stakeholders to work collaboratively together to deliver wrap around services. Driven by the person's own goals, needs and desires, a connected approach to service delivery would significantly reduce the risks for people experiencing homelessness, such as exiting an institution into homelessness, and ensuring that services are complementary of each other and are informed by the individual's plan for achieving mental wellness.

Additionally, in recognition of the vast experiences, life stages and aspirations of people with mental ill-health, flexibility needs to be built in to government policy to ensure that people are not disadvantaged by structures that create square peg / round hole situations.

There needs to be a significant shift in the approach to delivering mental health support across health and non-health sectors in order to improve the ability of the various services to provide an integrated network of supports. Coordinated case plans which cover the breadth of services a person might need and provide linkages between housing, justice, health, GPs, NDIS, community groups and Not-For-Profits (NFP) would aid in forming this connected network.

However, policy and system reforms are needed to truly enable and encourage the collaboration required by services to deliver.

People experiencing mental ill-health encounter many touch points with the system and within the community. To ensure appropriate action and referral and improve understanding, the ability of staff and community members across these areas to work with people experiencing mental ill-health must be improved.

Samaritans recommends federal, state and territory led education programs. These should focus on mental health awareness, mental health first aid, trauma informed care and alcohol and other drugs (AOD) training that target specific areas of the community and workforce. While training and education for some should be mandated (for example mental health first aid, trauma and AOD for police force, teachers, NDIS planners), others might be delivered as part of community awareness, employment and school programs.

The aims of this kind of broad approach to education include:

- Improve mental health literacy in the community
- Improve awareness of appropriate services for referral
- Reduce stigma in workplaces, schools and community

- Improve partnerships across services
- Improve the ability of the justice, education and not-for-profit sectors to work with people experiencing mental health issues in a constructive and supportive way.

Samaritans also advocates for easier pathways to accessing mental health services. We observe for example that people are often turned away when presenting at hospital. Providing soft entry points, improved referral pathways and better access to early intervention and prevention programs are key, but mental health services must also be accountable for engaging with people when they present for help.

Quality of Living and Connection

Employment and income security

Often the greatest barriers experienced by those trying to access the disability support pension (DSP) is accessibility. While the amounts are usually enough to support basic human needs when combined with financial management assistance, other welfare benefits such as the low income health care card and social housing, the DSP in particular is difficult for some people with mental illness to access and difficult to get support to apply for. It also does not represent a great enough amount to have an 'average' standard of living and combined with the complexities presented by chronic mental health issues it can be difficult for people on the DSP to participate fully in social and community arenas.

Given the difficult process undertaken to access the DSP, one of the greatest concerns for those receiving it is their ability to revert to it if they take up work and subsequently become unwell again. Flexibility is required in government processes and systems which allow people to return to the workforce without fear of having no income should they need to exit the workforce again because their mental health declines.

Enabling access to a single key contact, likely a mental health case manager, to assist with all aspects of their recovery and ongoing mental wellness would go a long way to improving peoples ability to engage in and sustain employment in the open market, but also to support the coordination of the many facets of their support.

Stigma

Building on the recommendations regarding education, federal, state and territory governments should be encouraging employers to hire, support and engage ongoing with staff with mental illness. Campaigns and programs that provide education for businesses might cover:

- The support available to them when working with people with mental health issues

- How to provide flexibility in the workplace to support staff with their mental health needs
- Staff programs that support stress reduction and work life balance, caring for yourself and colleagues, eliminating bullying and improve awareness of mental health issues
- Training for managers and HR staff on indicators or identifying precursors of mental ill-health, mental health first aid, awareness and reducing stigma
- Introducing programs that advocate for peer support strategies.

Social connection

There appears to be little local level activity from governments which specifically target social participation and inclusion. As government focus is on high-level systemic changes and meeting the needs of society, it is important that governments at all levels take part in addressing some of the systemic barriers that people with mental ill-health suffer in relation to social participation and inclusion.

Provided below are examples of government activity in two of the regions in which Samaritans operate. The first from within the health sector and the second from local council. Neither demonstrate focus or recognition of the benefits of targeting social participation and inclusion on the mental health of their target cohorts. You will find following the two local examples a more active example from a federal level.

Mid North Coast Local Health District (MNCLHD)

Mental Health Services Clinical Services Plan 2013 – 2021

The Mental Health Clinical Services Plan contains no dedicated focus on improving social participation and inclusion at a local level.

However, they do note some programs funded by their office such as Resource and Recovery Support Program through New Horizons which provides specific assistance to identify and engage in activities in the community.

The plan also quotes the Council of Australian Governments (COAG) National Action Plan on Mental Health 2006-2011 and notes the mental health reform focus areas under this plan which included ‘Encouraging economic and social participation, including jobs for people with mental illness’ (MNCLHD, 2013).

Many of the guiding principles and recommendations of the MNCLHD Mental Health Clinical Services Plan support the themes of our paper and include focus on:

- building capacity of current facilities and staff to continue to meet the needs of the region
- establish a consortium of service providers, government and other key stakeholders to engage in a collaborative partnership
- improving connectivity between different services and the key government departments to enable supported release from acute inpatient services
- improving engagement with people with mental ill-health and their carers
- prevention and early intervention with an ‘emphasis on reducing the burden of illness caused by mental health conditions’ (MNCLHD, 2013, p. 15)

Newcastle City Council

Newcastle 2030 - Community Strategic Plan

While not linked directly to improving mental health in the region, the NCC Strategic Plan includes multiple targets which are focused on improving connection and social interaction within the Newcastle Community. The key related sections of the strategic plan fall under section 4, Inclusive Community, which include the following targets and activities:

- ‘4.1 A welcoming community that cares and looks after each other*
- 4.1b Support initiatives and facilities that encourage social inclusion and community connections*
- 4.1c Improve, promote and facilitate equitable access to services and facilities*

4.2 Active and healthy communities with physical, mental and spiritual wellbeing.

4.2a Ensure people of all abilities can enjoy our public places and spaces

4.2c Promote recreation, health and wellbeing programs'

(Newcastle City Council, 2018)

These are specific examples of activities at a macro level that can be undertaken by local government departments to contribute positively to social participation and inclusion, however the federal, state and territory governments also have a role to play.

Council of Australian Governments (COAG)

The Roadmap for National Mental Health Reform 2012-2022

Priority 6 of the COAG's roadmap include specific focus on the benefits of and strategies to 'Improve the social and economic participation of people with mental illness'. The strategies presented support the statements and recommendations made throughout this paper and include:

'39. Promote the development of inclusive and supportive workplaces, encourage better workplace design that accommodates those with mental health issues, and support improvements in employers' capacity and willingness to hire, retain and re-engage people with mental health issues and their carers.

40. Improve access to affordable, appropriate and secure housing for people with mental health issues or mental illness.

41. Improve the competency of early childhood and education providers and their access to appropriate and flexible education for young people with mental illness, mental health issues or significant emotional or behavioural challenges (including adjusted learning needs), extending this access to people with caring responsibilities.

42. Improve the awareness of and coordination among service providers to ensure that the education and employment needs and

potential of those with mental health issues are identified, recognised and realised.

43. Support the development of social enterprises that increase the participation of people with mental health issues in education, employment, and in their communities.

44. Provide greater support for families and carers so that they, too, can live full and rewarding lives and can participate in education, employment and the community.’ (COAG, 2012)

Non-government organisations, as well as health professionals, play a more active role at a local level in supporting social connection and inclusion. This might include:

- connecting individually with people with mental health issues to gain insight into their needs and help them to develop goals
- delivering community programs that encourage social inclusion and participation
- contributing to research, piloting new programs and providing feedback and data to inform improvements in program delivery
- being an “on the ground” observer of a person’s wellbeing and collecting information about the ways their mental health improves or declines in relation to their social activities and participation. Feeding this back to medical professionals to aid them in understanding their patient and providing the best care to them
- advocating for the needs of the people they support and educating the community on mental health issues

One example of a local solution is the Endeavour Clubhouse Port Macquarie which is based on the Clubhouse International model. This model has been operating since 1948 in the USA, and there are now more than 290 Clubhouses worldwide with multiple across Australia. Their programs focus on enabling people to be active in their own recovery and involve:

- employment and work participation
- accessing the community and attending to essential human needs such as housing and transport

- social and recreational activities
- outreach through phone calls or hospital visits
- education and prevocational training
- physical health.

There has been research conducted into the outcomes and effectiveness of Clubhouses internationally with some evidence supportive of the model and the benefits to the people who participate (McKay, Nugent, Johnsen, Eaton, & Lidz, 2018). Clubhouse International quote various research evidencing outcomes for Clubhouse Members (Clubhouse International, 2019) including:

- Longer employment tenure
- More affordable model than other mental health treatment models
- Decrease in hospitalisation
- Reduced contact with the criminal justice system
- Improved health and wellbeing
- Closer relationships

Some indicators that may prove useful to monitor improvements in mental health and outcomes achieved through social participation and inclusion initiatives include:

- Employment participation rates and rates of absenteeism
- Education participation rates and rates of absenteeism
- Rates of admission and re-admission to hospital
- Repeat engagement with services
- Reduced presentation to mental health professionals

Specific Issues

Early intervention

The Everymind Prevention First Framework suggests a broad multi-layered approach to addressing mental ill-health with a clear focus on promotion, prevention and early intervention. Some of the strategies they suggest, which we have targeted at specific levels of society include:

Federal, state and territory governments

- Building health public policy e.g. reducing stigma, improving access to transport and other services

State, territory and local government

- Creating supportive environments e.g. anti-bullying programs, mentoring and peer support, supported accommodation

Local government, education settings, workplaces and community

- Strengthening communities to take action e.g. community-based suicide prevention

Service providers, medical professionals, individuals and their carers

- Developing personal skills e.g. life skills training, coping skills and emotion management strategies
- Reorienting services e.g. to focus on prevention, to promote recovery, to be age or culturally appropriate

Service providers and mental health professionals play a key role at multiple levels, in delivery of programs or services, advocacy, participating in research, piloting and championing new programs and initiatives and connecting the levels through communication and collaboration.

Youth and trauma

The most important aspects of child protection programs currently operating in Australia, focus on early intervention and addressing trauma.

Trauma is often a precursor to mental illness and addressing trauma in children requires skilled child psychologists qualified in trauma informed care. Improving awareness across the sector around the impacts of trauma

and the relationship to mental health conditions would make a significant difference to the treatment outcomes.

Implementing and enforcing training in trauma informed care for educators, carers, youth workers, community and youth groups, medical care professionals, and formal sporting clubs would aid the appropriate identification of issues and referral to skilled psychologists before mental health conditions progress.

School targeted prevention and promotion programs would contribute to early intervention and identification. These should focus on:

- improving awareness and understanding of mental health issues for teachers and students
- skills building to identify issues and provide referral or self-refer
- introduce programs that act as soft entry points such as drop-in centres and after school activities
- ensure that schools celebrate relevant events that encourage connection and community, such as RU Ok Day, Naidoc Week and Youth Week
- improving connection between local services such as headspace and schools.

Interconnected approaches to addressing mental health issues for children and young people, such as the NEXUS unit at John Hunter Hospital Newcastle, incorporate services such as psychiatry, education, social work, NGO service provision and nursing to offer a wraparound approach to improving the mental health of the children and young people (5 to 17 years) who are admitted as in-patients.

Limited access to specialist services in regional areas such as acute mental health care, programs like headspace or even child psychiatrists, mean that families must travel many hours to access appropriate services. This can exacerbate existing issues or introduce new challenges such as separation from family and community, and loss of employment and relationship

breakdown for carers. Improving access to specialist services for children and young people in regional and remote areas would reduce some of the significant pressure on families, improve speed of recovery and increase chances of positive outcomes.

Justice

Currently there are few appropriate community and therapeutic programs which focus on preventing people living with mental illness coming into contact with the justice system. One repeating theme that is apparent to Samaritans is the lack of continuity in support or acceptance into a program or service for people presenting with acute mental health issues.

Samaritans strongly advocates for preventative and early intervention programs for long term sustainable change, however there is an identified and immediate need to improve accessibility for those whose mental health has deteriorated significantly. Those people are often under-supported by the mental health system, including hospitals, and are either not admitted when they need help or are discharged before they are ready. Worsening mental health conditions lead to risk taking behaviour which can then result in contact with the justice system. It follows that reforming entry pathways into acute care and providing higher levels of support for those people presenting with risk taking behaviours will result in lower rates of contact.

Diverting a person with mental health issues into community programs and away from prison should be a priority to reduce repeat offending. Ensuring that trauma and mental health issues are correctly identified, and the various interrelating complexities (e.g. intellectual disability, poverty) that impact mental health are understood, will enable identification of appropriate alternative referrals in place of incarceration.

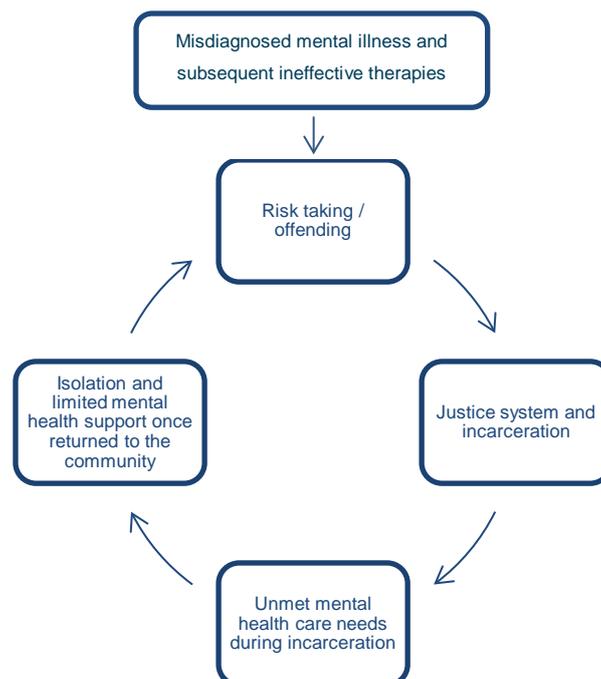
Samaritans observe significant issues in the justice system which impact directly on the mental health of prisoners and prevent them from improving their mental health:

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- no focus on therapeutic education, healing or rehabilitation. Only “punishment” which is inherent with the correctional system as it is a punitive approach
- release of prisoners into homelessness and without social supports (unless they are on a Community Treatment Order)
- disruption to medications on exiting
- pre-existing mental health issues and trauma not addressed
- institutionalisation not addressed either in prison or post-release

The Samaritans UK (unrelated to Samaritans Foundation) offer a program called the Listener Scheme that runs peer mentor programs in prison to help prevent suicides in custody. The program has been very successful and subsequently widely adopted by the justice services in the UK with the program active in almost all prisons in England, Scotland and Wales, and many in Northern Ireland and the Republic of Ireland as well (Samaritans (UK), 2019).

Misdiagnosis can contribute to young people entering and repeatedly coming into contact with the justice system. Addressing the trauma that often lies behind mental illness would help to break the cycle:



To reduce the likelihood of re-offending, the system might incorporate:

- Providing people with the information or resources they need to explore their behaviour, where it stems from, what purpose it serves for them and how to find purpose in positive ways
- Post-release services that provide wrap around support and include support to access housing, casework, health and wellbeing programs, education, employment readiness training, mental health assessments and therapeutic programs
- Alternatives to incarceration such as community service, group work and individual therapies which support people to develop a sense of belonging and purpose
- Post release programs such as Samaritans Recovery Point which provides support to those leaving prison with assistance to find accommodation, access services like Centrelink and get an ID while engaging in work, education and/or social activities.

The NSW Bureau of Crime Statistics and Research (BOCSAR) has data that supports alternatives to incarceration in reducing re-offending. For example, data explored in 2017 determined that there was an 11%-31% reduction in the odds of re-offending for people who received an intensive correction order (ICO) instead of a prison sentence up to 24 months (Wang & Poynton, 2017).

The below summary provided on the BOCSAR website also shows strong support for alternatives to incarceration:

	% of people convicted (by year) who received a penalty other than prison who were reconvicted of another offence within the next 12 months			% of people exiting prison (by year) who were reconvicted of another offence within the next 12 months		
	2015	2016	2017	2015	2016	2017
Adults	20.3%	20.8%	20.6%	41.0%	41.0%	41.4%
Juveniles	44.6%	42.0%	44.3%	66.0%	63.8%	64.7%

Table 1 (Bureau of Crime Statistics and Research, 2019)

Dual Diagnosis

Dual diagnosis refers to the presence of mental illness with a substance use disorder. This is an issue that impacts on a number of the people presenting to our services.

In the first report of the Senate Select Committee on Mental Health, which was tabled on 30 March 2006, the issue of dual diagnosis was the subject of a full chapter. Extracts from this report remain relevant to our services over 13 years later:

'14.63 People with dual diagnosis have been characterised as 'the forgotten people' of the mental health system. They have more difficulty accessing services than any other people experiencing mental illness and their life circumstances reflect this.

14.65 However, while these factors are important, the main problem for the dual diagnosis group is that they fall outside of the discrete treatment spectrums of the mental health system on the one hand, and alcohol and drugs services on the other.

14.68 Under current service criteria, people with alcohol and drug problems can be turned away from mainstream mental health systems, which are not required to treat substance affected people. Meanwhile drug and alcohol services may also reject clients with mental health problems. People with dual diagnosis are thus effectively excluded from both 'service silos' and left to wander from provider to provider seeking treatment.'

(Senate Select Committee on Mental Health, 2006)

In our services, including post-release and homelessness, there are still a large number of clients who have a dual diagnosis and their experience of the service system is consistent with the very issues identified back in 2006.

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