



**Submission on the Draft Report of the Inquiry into Mental Health
Productivity Commission**

January 2020

Settlement Services International

Settlement Services International (SSI) is a community organisation and social business that supports newcomers and other Australians to achieve their full potential. We work with people who have experienced vulnerability, including refugees, people seeking asylum and culturally and linguistically diverse (CALD) communities, to build capacity and enable them to overcome inequality. In late 2018, SSI merged with Access Community Services Ltd in Queensland which significantly extends our service footprint and reach.

SSI and Access provide a range of services in the areas of humanitarian and migrant settlement, services to people seeking asylum, employment support, Out-of-Home Care, enterprise facilitation, disability and social and cultural inclusion initiatives. In 2018-19, SSI and Access provided direct services to more than 40,000 people in programs mainly funded by the Australian, Queensland and NSW governments.

SSI and Access are well placed to comment on this discussion paper. In doing so, we draw on our extensive experience engaging with and delivering a breadth of human services to people impacted by mental ill-health including refugees and people seeking asylum, children and young people from culturally and linguistically diverse backgrounds in statutory care, people accessing employment support and people with a disability from culturally diverse backgrounds.

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General Comments

Settlement Services International (SSI) welcomes the Commission's examination of the case for reform in health services and other human services to address and prevent mental ill-health. We particularly welcome the work of this inquiry in quantifying the social and economic costs of mental ill-health and suicide in Australia and the potential savings arising from the proposed reforms to our society and economy. We also welcome the emphasis in the inquiry's draft recommendations to broaden the response to treat and prevent mental ill-health to a wider range of human services including the education system, housing support, the justice system and employment support services.

We support the draft recommendations to develop a whole-of-government mental health strategy, an expanded role for the National Mental Health Commission, universal access to after-care in suicide prevention and a stronger emphasis on monitoring and evaluation and building the evidence base for the prevention and treatment of mental ill-health.

We also welcome the inquiry's acknowledgement of the pivotal role of culture in understanding and treating mental ill-health and delivering early intervention and prevention. In SSI and Access' service delivery to refugees, migrants and people from culturally and linguistically diverse (CALD) backgrounds, we see first-hand the impact of culture on preventing and addressing mental ill-health. These impacts often mirror the barriers that people from CALD backgrounds experience in navigating the health system for physical health conditions including poor health literacy. However, in the area of mental health, these barriers are exacerbated by significant stigma, arguably even more opaque pathways to care and language barriers (given that treatment of mental ill-health often entails some form of 'talking therapies').

We recommend that the Commission consider adopting a public health lens as an overarching framework for these proposed reforms, including a whole-of-government Mental Health Strategy [**Draft Rec. 22.2**]. Such a lens has been a critical frame in Australia's success in other areas including tobacco control and HIV prevention. These successes involved not only a whole-of-government approach but rather a whole-of-community approach which we would argue is also needed to deliver the gains needed to prevent and treat mental ill-health.

A public health lens is consistent with the Ottawa Charter for Health Promotion and a multipronged whole-of-community approach encompassing improving awareness and personal skills, reorientating health services, strengthening advocacy and community action, and building healthy public policy [1, 2]. This would appear be consistent with the strategic intent of the suite of draft recommendations in this inquiry.

The draft report and recommendations are virtually silent on the role of non-government and community-based organisations (other than references to peak advocacy bodies) that deliver a range of human services to vulnerable individuals and communities. In our view this is a missed opportunity as the non-government sector offers substantial infrastructure, that is already engaged with individuals and communities impacted by mental ill-health, that could be tapped into and mobilised to deliver a a whole-of-community response to mental health. In our view, this capacity should be recognised and integrated into the draft recommendations in relation to the proposed Mental Health Strategy and enhancing consumer and carer participation [**Draft Recs. 22.2 & 22.3**]. This could help to incentivise investment in the non-government sector in the prevention and treatment of mental ill-health, particularly in programs know to reach groups with high levels of psychological distress, and help deliver on the promise of this inquiry to improve the response to mental health for all Australians.

We welcome the inquiry reaffirming the role of stepped care and the need for a reorientation of health services to consumers so that it is configured to give all Australians access to care that is timely and culturally appropriate **[Draft Rec. 5.9]**. However, we would like to see a stronger articulation on how this reorientation to consumers and culturally appropriate stepped care could be achieved as part of these reforms. With almost a quarter of Australians being from a CALD background (e.g. 22 per cent of the population speak a language other than English at home [1]), it is imperative that a more systematic and intentional approach is adopted to ensure that treatment and care in mental health is accessible and culturally competent.

We have seen from other major reforms, such as the NDIS, that people from CALD backgrounds (and other vulnerable populations) can be left behind despite the significant levels of new investment [2]. For example, the findings of the evaluation of the trial of the NDIS by the National Institute of Labour Studies found that while the NDIS has improved the lives of people with disability overall, it has left several minorities, including people from CALD backgrounds, no better off or even in a worse situation [3]. The evaluation identified several issues, including service supports, workforce, participation, and equity and access [3]. Similarly, the Productivity Commission's 2017 NDIS Costs – Study Report noted that "... not all are reporting improved outcomes under the NDIS" and identified groups, including those with a psychosocial disability, language and cultural barriers, transitioning from the criminal justice system, the homeless and socially isolated as being at risk of having poorer outcomes [4].

In SSI's view, and in light of the inquiry's acknowledgement of the pivotal role of culture in mental ill-health, the Commission should amend the draft recommendation on the reorientation of health services **[Draft Rec. 5.9]** to include that it be guided by a cultural competency framework across health services. A good example of such a framework has been developed by the National Health and Medical Research Council with the four levels of action across systemic, organisational, professional and individual domains [5] to deliver comprehensive systematic change in health service delivery. Adopting such a framework would strengthen the potential for the proposed reform in this area to reach vulnerable and underserved populations impacted by mental ill-health including Aboriginal and Torres Strait Islander people and people from CALD backgrounds.

SSI strongly supports the expansion and integration of online treatment options as part of stepped care in mental health **[Draft Rec. 6.1]**. These options have the potential to reach populations who have traditionally not accessed other treatment modalities for mild to moderate symptoms in a cost-effective way. SSI was involved in a partnership, led by the Refugee Trauma and Recovery Program at UNSW, which piloted online treatment, Tell Your Story, to address PTSD among newly arrived refugees which demonstrated promising results [6]. SSI therefore sees merit in expanding these online treatment options for people from CALD backgrounds **[Info. Req. 6.1]**.

SSI is unable to comment on the specific circumstances where supported online treatment would be cost effective for people from CALD backgrounds **[Info. Req. 6.1]** but we note that they can be offered in multiple languages (Tell Your Story was in three community languages and English). Importantly, our experience suggests that they offer a critical pathway, when developed in culturally competent ways, to reach underserved individuals with mental ill-health from CALD backgrounds. Cost-effectiveness can focus too narrowly on effectiveness of treatment outcomes while overlooking other outcomes where an online intervention might show promise in reaching people who might not access other treatment modalities. We

therefore urge the Commission to include the **reach** of online supported treatment alongside cost effectiveness considerations.

SSI is also unable to nominate a language or cultural group for the expansion of a trial of online supported treatment [**Info. Req. 6.1**]. However, we recommend that the priority groups of a trial should be targeted after considering: the size of the community; the community's length of residence in Australia; the community's English language proficiency and be geared towards humanitarian entrants.

In addition to online supported treatment, SSI sees merit in using online platforms to improve awareness and mental health literacy among migrants and refugees arising from our learning in the New Roots initiative. New Roots was developed and piloted by SSI in partnership with *beyondblue* with funding from The Movember Foundation (see below in Part IV).

SSI cautiously supports an information campaign to expand awareness of supported online treatment [**Draft Rec. 6.2**] though we query whether the Australian Government is best placed to deliver a campaign of this nature. A risk is that a large marketing campaign will not effectively reach the marginalised populations that have the highest burdens of psychological distress.

SSI supports an evaluation of the MBS-rebated psychological therapy initiative [**Draft Rec. 6.4**] but recommends adding an explicit reference to examining the past utilisation of the program by a range of potentially underserved population groups, including Aboriginal and Torres Strait Islander people and people from CALD backgrounds, to guide future planning and targeting of this critical MBS initiative.

In relation to measures to strengthen the peer workforce [**Draft Rec. 11.4**], SSI recommends that the peer workforce be built with an explicit consideration of cultural diversity from the outset to ensure that this peer workforce is reflective of the cultural diversity of Australians.

Part III Reorienting surrounding services to people

SSI broadly supports the range of recommendations to improve care integration and coordination, inclusive of carers and families, and broadening the response to mental ill-health to a wider range of human services including: services for people with insecure housing; people in contact with the justice system; people accessing income support; and, people accessing employment support services (jobactive and DES). We particularly welcome the inquiry highlighting various areas of public policy that potentially exacerbate mental ill-health (e.g. mutual obligation requirements) and a draft recommendation to improve the consistency of mental health assessment in employment support services [**Draft Rec. 14.1**].

Part IV Early Intervention and Prevention

SSI welcomes the focus on early intervention and prevention in the draft recommendations and supports the proposed investment in universal early intervention and prevention across the lifespan from preschool to tertiary education [**Draft Recs. 17.2-17.6 and Draft Recs. 18.1 to 18.3**].

However, we would argue strongly for embedding early intervention in other settings including, for example, settlement services for refugees, foster care providers and disability support services. These kinds of

programs offer an opportunity to deliver targeted early intervention and prevention to populations known to have a higher prevalence of psychological distress. Further, these programs already have an existing rapport with these individuals and significant reach in communities as they are typically delivered by non-government and other community-based organisations. These organisations are ideally placed to respond and prevent mental ill-health and address the intersectional issues that heighten vulnerabilities and compound psychological distress. These organisations are already attuned to the needs and aspirations of their clients and communities and are well-placed to overcome barriers arising from mental health stigma through offering mental health support as part of an integrated suite of human services in ways that are culturally competent.

New Roots case study – an early intervention and prevention initiative



Here we consider refugees and the lessons learned from the New Roots initiative which was developed and piloted by SSI in partnership with *beyondblue* with funding from The Movember Foundation. Refugees settling in Australia have high levels of psychological distress attributed to traumatic experiences in countries of origin and transit, and post-migration stressors of adapting to a new country. They are typically seen as ‘hard-to-reach’ in terms of mental

health due to the intersections of stigma and cultural, linguistic and gender norms.

New Roots piloted an approach to address these issues in settlement programs and developed:

- An app in English and three community languages to promote mental health self-assessment and wellbeing;
- An Online Toolkit for settlement staff to support them in promoting the mental health of their clients, including using the app as a tool to complement casework; and
- Community engagement initiatives with Arabic, Farsi and Tamil-speaking community leaders to increase awareness of the app and ways to promote mental health among their communities.

Key findings from the external evaluation of the 12-month pilot phase in NSW [7] included:

- strong reach among target users (young refugee men), with more than 3,700 downloads of the app;
- strong engagement with the app (in terms of average session time), high levels of acceptability reported by users and refugees regularly using the in-built mood-mapping tool;
- the Online Toolkit promoted understanding of mental health and use of the app to frontline settlement staff;
- and engagement with community leaders increased awareness and understanding of the goals of New Roots and promoting mental health.

This multipronged approach developed by SSI and *beyondblue* allowed each organisation to bring different sets of expertise to New Roots which was developed iteratively. Crucially, this was able to tap into SSI’s existing contact with refugee men to develop the initiative in ways that overcame many of the barriers and stigma arising from the intersections of stigma and cultural, linguistic and gender norms.

We welcome the development of a National Stigma Reduction Strategy [**Draft Rec. 20.1**] and a coordinating role for the National Mental Health Commission. However, we have doubts about the capacity of a centralised national agency to sufficiently tailor stigma reduction messages. We urge the inquiry to reshape the role of the National Mental Health Commission in stigma reduction to national coordination and instead commission local non-government and community-based organisations to deliver stigma reduction initiatives under the National Mental Health Commission’s stewardship.

The inquiry is seeking information on the difficulties that international students have in accessing mental health services given their temporary residency status [**Info. Req. 18.3**]. In SSI’s and Access’ work with migrants and refugees we are aware of significant barriers in the area of mental health due to the intersections of stigma and cultural, linguistic and gender norms. Given the typical age-range of international students, we see particular merit in the use of online treatment and awareness raising initiatives similar to those that have been canvassed in this submission (i.e. Tell Your Story, New Roots) to address these barriers. These online and mobile-based initiatives could provide students with mild to moderate psychological distress access to prevention and treatment and be a pathway for those with more severe distress to seek appropriate clinical care.

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