[breakthru]

breakthru Submission to the Royal Commission into Victoria's Mental Health System

To support their inquiry into the role of improving access to mental health services, navigation and models of care.

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Empowering people with disability to achieve their goals for over 25 years

Introductory letter

I would like to commend the Victorian Government for initiating this Royal Commission to bring about positive change in the mental health system and enable Victorians to experience their best mental health. As an experienced mental health and disability service provider since 1993 and significant stakeholder with the disability services sector, we are pleased to contribute to the discussion on the benefits of greater access to mental health and mainstream services for people living with mental illness. This investigation comes at a critical juncture in the provision of community mental health support with the roll-out of the National Disability Insurance Scheme acting as a catalyst for broad reform in the provision of services.

While our paper considers the Mental Health system and its vital role in treating mental illness, we would also like to highlight the importance of linking and supporting people in the community (for example to access employment) concurrent to their treatment as an important factor to recovery.

Australia's record of employing people with disability (including people who experience mental illness) is poor when compared with other OECD nations (Australia is ranked 21st out of 27 nations). With almost half of all Australians experiencing mental illness at some point in their life, we have an opportunity to adopt a national approach to what is a national issue that affects every business and the capacity for people with mental illness to access employment.

However, we have witnessed a worrying trend of federal and state governments drawing lines in the sand over funding responsibility, and an ever widening gap in services for people who require support to actually receive support. The benefits of early intervention up-stream supports that focus on recovery have been long proven to significantly reduce the adverse impact and escalation of mental ill-health and conversely reduce recovery times and the long term economic impact. The research points to the vast personal benefits of people being able to engage in the community and employment. There is a very real personal benefit for being engaged in employment for those individuals who experience mental illness, including greater inclusion in the community and periods of general wellbeing.

breakthru is an Australian for purpose organisation whose core vision is to advance 'Seamless Inclusion' for the people we support. We deliver extensive services throughout QLD, NSW and VIctoria for people who experience mental ill-health, including employment, homelessness and community mental health services.

In preparing our response, breakthru sought the views of a number of stakeholders including participants of mental health and employment services, family and carers, support staff and subject matter experts. The following submission outlines the key findings of this feedback and subsequent recommendations.

Authorising Signature:

Paul Stiff
CEO
September 2019

Contents

Executive Summary

This report is in response to the call for submissions from the Royal Commission regarding it's inquiry into the role of Victoria's mental health system in improving the mental health of Victorians.

breakthru delivers a range of mental health services in Victoria, Queensland and NSW, including: Commonwealth funded Personal Helpers and Mentors Program (PHaMs); Family Mental Health Support Services (FMHSS); and Mental Health Respite Carer Support (MHRCS); and in Victoria Mental Health Community Support Services (MHCSS); Early Intervention Psychosocial Support Response Service (EIPSSRS); Pathways Homeless Program; and Prevention and Recovery Care Service (PARC) (sub-acute residential facility).

Additionally we deliver Disability Employment Services (DES) in NSW and Qld with specific mental health specialisation (psychiatric disability) and specialise in mental health support through the NDIS (Department of Social Services) (where we support 300 people who have or will transition to the NDIS from community mental health programs).

This submission explores stakeholder feedback from a range of different programs and perspectives as well as drawing on our experience in delivering services for people with mental illness. The key areas of this submission are the challenges faced in the mental health sector including the effectiveness of current programs and the workforce, the role of carers and the support available for them, the importance of social participation and inclusion, and the role the education and employment systems play in achieving economic goals. In response to these challenges, our report not only highlights the existing problems identified by stakeholders, but also aims to address the issues by offering a number of solutions.

This submission therefore concludes with a summary of the problems and a list of recommendations for the Productivity Commission to consider including recommendations around **(1)** supply and support for our workforce, **(2)** building community awareness and capacity, **(3)** increasing the knowledge and options for people living with mental illness, **(4)** policy direction for homeless services, and **(5)** policy direction for education and employment services.

Methodology

breakthru conducted a mixed method research study through a range of focus groups, online surveys and 1:1 interviews. The method of research differed depending on a range of variables including the support needs of the research participants, sensitivity of the subject matter, the ability to organise focus groups and resourcing, and the likely 'yield' of responses.

breakthru identified five key areas that we determined we could bring the most value to given our expertise. These were; **(1)** Health workforce and informal carers, **(2)** Social participation and inclusion, **(3)** Housing and homelessness, **(4)** Education and training, and **(5)** Employment and employment support. We developed questions based on these five key areas and written in simple English format, to ask focus groups and these are published in this report.

Consultation details are as follows:

(1) For the topic of health workforce and informal carers we conducted two focus groups and distribution of online surveys. One focus group consisted of eight participants of breakthru's NDIS school leavers employment service, counselling service and one-on-one community participation service. The second focus group consisted of ten mental health support workers from breakthru's NDIS counselling service and FMHSS service. Additional online surveys were completed by families and carers and workers,

(2) For the topic of social participation and inclusion we conducted one focus group consisting of PHaMs participants and distributed surveys to participants in our DES (psychiatric specialist contract) program.

(3) For the topic of housing and homelessness we conducted one focus group of participants of our Pathways homeless program and residents of our PARC facility Melbourne.

(4) For the topics of education and training and employment we combined the questions in the Issues Paper. Similar to the topic of social participation we conducted one focus group consisting of PHaMs participants and distributed surveys to participants in our DES (psychiatric specialist contract) program.

Participation in the focus groups, surveys and interviews was completely voluntary and feedback was confidential. All focus groups had a broad mix of ages and genders and were conducted in an open focum manner with respondents able to openly discuss answers individually and as a group. Some of the challenges of focus groups was ensuring every participants had an opportunity to give their input and comprehending some of the questions correctly. Some of the challenges with the online survey was promoting them to a broad base to ensure we received responses across a number of our programs.

The feedback obtained through focus groups was consolidated by subject matter experts in the fields of mental health workforce, social participation, homelessness, education and employment, capturing common themes raised. SMEs also captured the perspective of breakthru, the challenges faced in each field and recommendation on how to address these challenges.

Stakeholder feedback

In this section, we asked participants, carers, job seekers and members of our workforce their perspective on some of the key areas of the Submission. We conducted a number of focus groups, 1:1 interviews and online surveys depending on the cohort group involved and the questions we focussed on.

Feedback on health workforce and informal carers

For this series of questions we conducted two focus groups and additional online surveys were completed by carers and workers.

One focus groups consisted of eight participants of breakthru's school leavers employment service and mental health service, who receive counselling and one-on-one support. The second focus group consisted of ten mental health workers from both breakthru's NDIS counselling services and Family Mental Health Support Service.

1.   Do you trust in the workforce used to deliver the services that you receive?

The majority of respondents to both the survey and the focus groups stated that they do trust the workforce to deliver services that they use. The majority also stated that because the workers they use have experience in the sector it gives them greater confidence in the supports they recieve.

> "They have experience in the sector which helps me trust them and feel comfortable when they support me"

The workforce focus group responded to this question by agreeing that they do trust in the service they deliver to participants because it is person centered, evidence based and it delivers good outcomes for the individuals supported. It was agreed that funded programs (like FMHSS) were important as it was free for participants and reached areas and people that are not able to reasonably afford or access support.

2.   Is there anything that you would change about the workforce that you use? If yes, what would you change?

Every respondent said they would change something with the support they receive. Common themes around funding (NDIS) and funding restrictions (FMHSS) were raised. The common view expressed was that funding was too limited and didn't translate to sufficient support in terms of regularity (e.g. counselling through the NDIS) and duration (e.g. FMHSS families are restricted to 12 months of support).

Worker turnover was also raised, tying into question 5 of the survey. Respondents from each of the three focus groups and the homelessness focus group commented that workers needed to be better educated around disabilities.

The changes suggested by the support worker focus group included standardising training and increasing exposure.

3. Are qualifications important to you when you chose a support worker?

Respondents to this question were divided in their opinion.

For half of those responding, qualifications were an important factor when choosing a support worker as it increased their trust in their ability to provide support. The other half felt that experience outside of university was more important.

Workers stated that parents do care about the qualifications they hold as it gives them reassurance and in the case of providing supports under an NDIS model it is a criteria.

4. Have you ever had trouble finding a suitable support worker that meets your needs?

People felt that generally finding suitable workers was not a problem, however one respondent raised issues around gender and female dominated workforce.

The support worker focus group agreed that they are not always a good fit for the customers but were restricted due to gender imbalance in the industry for participants who would like a male worker. The group talked about the NDIS offering participants more choice with support worker and that this might encourage a shift towards a greater workforce diversity.

5. Support workers have a higher turnover rate than other professions. What could be done to reduce stress and turnover among mental health workers?

A high turnover rate was identified across multiple programs including mental health community programs, homelessness programs and vocational programs.

The key recommendations to improve staff retention that were proposed across the surveys and focus groups are:

- Increased employee remuneration and rewards,
- Increased placement opportunities in the industry,
- Realistic KPIs and expectations,
- Increased self care options (health and wellness memberships, counselling, supervision), and
- Training (both formal and practical, (eg. conflict resolution skills).

6. Do you have informal carers involved in your support needs? (family member/ friends/ Unpaid support)

All respondents recognised the important role of informal carers in their lives.

7. *What changes should be made to how informal carers are supported (other than financially) to carry out their role?*

The following recommendations were made to support their informal support networks:

- Increased resources and education about mental illness
- Counselling services for families and carers
- Better communication between services and carers
- Increased funding
- 24 hr support

Additionally, the workforce group had these recommendations:

- Linking with free services in the community
  - parenting groups, support groups and counselling services
- Developing skills to increase independence as a family

Feedback on social participation and inclusion

1. *In what ways are governments improving mental health by encouraging social participation and inclusion?*

Two survey respondents commented that the NDIS was a positive step to improving mental health and creating opportunity for increased social participation. One respondent felt that having a support worker funded through her NDIS plan was very positive, while another made reference to the group activities they were able to access through the NDIS.

This was in contrast to the remainder of respondents who outlined their concern with the NDIS and the impact the change had on their health and wellbeing. Comments included,

> "The NDIS would be a way the Government was improving mental health if it is was run properly".

> "The Government is making it harder to get support for mental health by limiting services available via mental health funding".

> "The NDIS helps with that however by taking away community mental health services, it is not really an improvement. It is just shuffling money, more support needs to be added to people's plans to encourage employment opportunities."

For those customers receiving supports through PHaMs there was a feeling that the Government was not improving mental health or encouraging social inclusion. Respondents expressed that they thought more funding should be provided directly to NGOs. Comments included,

> "We want drop in centre supports back. It's a start to get us back in the community. When there was a drop in centre I never was on my own. When I was having a bad day I could go to the centre and be with people".

Other recommendations expressed from the focus groups was that the Government should communicate more often and more effectively, clearly outlining the opportunities available.

2.   What role do non-government organisations have in supporting mental health through social inclusion and participation, and what more should they do?

Survey participants felt that NGO's played a vital role in supporting mental health through social inclusion and participation. Respondents felt that the NGO sector "picked up people who fell through the NDIS cracks".

Respondents made particular reference to church drop in coffee meetings, neighbourhood kitchens and community health centres. Respondents felt that NGOs were doing all they could but were limited by government funding such as the NDIS. One respondent commented,

> "NGOs play a big role as their focus is not on medication and treatment, they have the ability to support people one on one to gain confidence"

When asked what more should NGOs do, responses included: offer more group based activities, more options for fun gatherings. One respondent suggested that NGOs should merge with local Council.

3.   What groups are more at risk of mental ill-health due to social isolation? What should be done to specifically target those groups?

There was a level of consistency in response to this question with respondents identifying the following groups as being more at risk,

- Indigenous Australians
- Young People
- Homeless
- Low socioeconomic communities
- CALD communities
- LGBTQI communities

Respondents felt that more specific services needed to be introduced to support different communities. One respondent felt that there should be a review of the eligibility for Disability Support Pension, recognising that many health issues have an impact on mental health. Respondents felt it should be easier and to access social workers and that schools should have more funding to run early intervention services.

4.   How do we know when people's mental health is improving because their social participation and inclusion has improved? What are the most obvious signs?

There was consensus that engaging in social activity itself can be a sign of improved mental health and that reaching out to people and participating socially was a positive sign. Respondents felt that having purpose and structure in their day was a sign of improved mental health. Respondents also commented that people smile more, access the community independently, take pride in appearance and health.

Feedback on housing and homelessness

1.   What strategies can governments and community agencies do more of to increase support to people with a mental illness who may become homeless or help people who are current homeless?

Several themes emerged from the focus group with a clear message on strategies to:

- Increase funding for specialised homeless programs with experienced workers who understand the cycle of homelessness and all comorbidities,
- Design Government and community groups that don't rehash the same 'housing worker' office based model who gives out limited vouchers,
- Operate hospitals and acute units that do not have the pressure for patients with no address to be discharged,
- Design innovative funding with opportunities for those sleeping rough to have 'safe havens' in parks, offices and and city spaces to sleep at night away from the public. Funding options would also provide opportunity for employment to earn money for accommodation,
- It's not just about support for people who are homeless, but early intervention support is also vital for those at risk:

"More funding to create specialised programs that assist with people who are at risk of homelessness."

2.   What strategies can governments and community agencies do more of to communicate better with other services who support people with their mental health or housing?

Respondents of our homelessness focus group suggested some innovative ideas around improving communication including:

- Information sessions that communicates where people can access material aids, food, showers, blankets, storage, etc as well as accommodation that is available,
- Provide access points in the community to offer help, information, housing availability and programs available to help,
- Education through awareness - T.V, radio, campaigns. This is to help reduce stigma and educate those on what factors eventually lead to homelessness,
- A central database so the housing history of a person is accessible,
- Funding for Case Managers to coordinate all aspects of a person's needs:

"Coordinator to help coordinate supports for each individual, to ensure that the person is supported all the way, at every point of their recovery."

3. **What strategies can governments and community agencies do more of to support people better who are discharged from hospitals, PARCS or prisons whose housing is not stable?**

Questions regarding discharging from units elicited a strong emotional response as participants felt that hospitals and prisons where not looking after people effectively, despite their remit to do so. Proposed strategies included:

- Prevention of people being discharged to no address. More support and information is required while people are admitted to avoid this.
- When discharging someone with housing issues, more is needed than a single GP referral or letter. An active worker must be made available for at least three months post discharge and up to a year where needed.
- More Prevention and Recovery Care (PARC) Services and a PARC for people leaving prisons.

"There needs to be more put in place so that people are supported in the most crucial part of their journey."

4. **What strategies can governments and community agencies do more of to be more flexible with government housing to respond to people with a mental illness?**

Participants expressed some frustration when questions regarding government housing were discussed. The process of applying and inadequate housing stock were prevalent themes:

- Build more houses
- Audit vacant houses and return them to available stock quickly
- Make applying easier and consistent. The current process is complex and changes too frequently
- Invite the general public to help with the issue. The public is not aware of how bad the wait list for housing is and if they did would 'step up'.

5. **Anything else that can be improved in regards to people with a mental illness who have housing issues?**

There was a consensus amongst the participants of the focus group that support for homelessness is under funded, that staff are inexperienced, that community agencies don't communicate well and that the community needs to step in and do more:

- More money is needed for more housing and specialised programs
- More money is needed to help co-occurring issues which lead to homelessness such as drug and alcohol misuse
- Community agencies need to talk more and have streamlined processes when needing to support the same client
- Workers require training to support everyone holistically.
- The Government has compartmentalised us all and does not seem to see us as a whole and the bigger picture.
- Standard rental agencies should be required to offer more support and help those in need. Agencies are too focussed on appearances and building bigger businesses to help those in need in the community.

Feedback on education and training

1.   *What is stopping you (or your child or young person) from participating in education and training and getting the most out of the experience?*

People responding to this question pointed to perceptions that the nature of their disability was the primary barrier for them participating in education and training opportunities. Specific symptoms that were identified as affecting people's capacity to engage in structured education and training included: lack of energy, feeling of pressure, anxiety and stress, poor memory, too many health appointments due to their condition, lack of confidence and motivation.

While these perceived barriers appear interpersonal in nature, they also reveal structural constraints in the current system to accommodate people who may have periodic absence due to episodic conditions or who may require additional support to access education and training opportunities. As one participant put it when responding to what was stopping them:

> *"Fear i cannot make commitment to be at a certain time and place for extended period of time and the fear of failure due to above."*

2.   *Is there enough support for you to keep engaged or to re-engage with education and training?*

While most respondents felt that there was enough support available for people who sought it out, people felt they were unable to commit to the constraints of formal training. The following quote was indicative of the challenge:

> *"No [there's not enough support]. If I miss a few days then I cannot catch up."*

Others felt that the support wasn't tailored to support their particular needs.

3.   *Is there support for you with your mental illness in your education setting? If so, what supports are most effective? If not, what are there gaps with support?*

Again, while respondents agreed that there was some support available through support workers for example, there needed to be more services made available. Supports that are most effective can be separated into structural, practical and cultural framework:

- Structural adjustments include how institutions adapt to the needs of students with disability including incorporating course flexibility and different modes of completing coursework to accommodate people who may need to take time off, or who may find campus learning or exam conditions difficult for example.
- Practical adjustments include direct supports around reading and writing, strategies to help with concentration, reinforcement and memory tools, etc.
- Cultural adjustments include training and capacity building for educators and support staff to ensure there is more understanding of mental illness amongst educators and education institutions.

4.   *Are the mental health supports available in education settings effective for students?*

Most people who responded were unsure with this question or said there was not enough. One person said it depended on the person providing the support. The scarcity of response to this question may also point to a lack of general awareness of the supports that are available in the training and education system.

5. *Are programs to educate teaching staff, students and families effective? Is there enough training? Is there enough support and advice available to be able to support students?*

Participants urged education providers to build their mental health awareness and support strategies for people with mental illness. Understanding that being nice doesn't always help.

Feedback on government-funded employment support

1. *How effective is DES and PHaMs in enabling people with a mental illness to find and keep a job?*

The responses to this question were mainly negative regarding their experience as participants of Disability Employment Services. Respondents felt that DES was not an effective program for people with a mental illness and that "DES was like Centrelink", with Centrelink positioned in a negative light.

Further comments included that employers who engaged DES jobseekers were only interested in the wage subsidies and that services were not interested in the person, just in getting people into any job regardless of its suitality.

Respondents agreed that PHaMs was a better program for people finding employment because the workers understood participants better and supported them with their 'issues' in a more holistic way.

2. *What elements of the program have been the most helpful and why?*

Jobseekers, through both the DES and PHaMs programs, felt that 1:1 individualised supports were the most helpful elements of employment programs (especially in PHaMs) including the support received through a peer support worker. The connections that DES has with employers and the on-the job support are important features of the program.

3. *Does this service help the people it needs to?*

Again, there was an underlying feeling that DES and PHaMs were not always reaching the people it was designed to help. This comment from one participant reflects this feeling:

> "Many fall through the gaps because they don't know the service exists or struggle to ask for support".

One respondent also felt that PHaMs could help many more people and that it was regrettable that it no longer exists.

4. *What other approaches would be better to support people with a mental illness (whether episodic or not) to find and keep a job?*

Participant suggestions regarding other approaches are categorised as:

- Existing approaches that currently exist in these programs, but that could be used more for people with mental illness. Such approaches include more Individual 1:1 Support and Ongoing support in the workplace.
- Supplementary support which works in conjunction with employment support that focuses on the needs of the individual. Support would include capacity skill building like anger management, goal setting and identifying priorities.
- Approaches that leveraged off existing supports including 1:1 training in the home and part-time traineeships. One respondent suggested bringing the best of the two programs (DES and PHaMs) together, so that DES services have more time to address the issues of the individual while still having the focus on getting the job.

5. *What other programs have been effective in enabling people with a mental illness to find and keep a job?*

Every respondent to this question indicated that they were unaware of any other program available for people with a mental illness to find and keep a job.

6. *How could employment outcomes for people experiencing mental ill-health be further improved?*

The prevailing attitudes of employers and the community were seen as a major barrier to employment outcomes for people with a mental illness. There was a general consensus that workplaces need to be more understanding of mental health issues and their limitations and that this would only be accomplished through broad cultural change within the community.

Other respondents felt policy changes were necessary to improve employment outcomes including providing financial security if the job does not work out (allowing a safety net for people on the DSP as it is difficult to re-apply for the DSP once discontinued).

One respondent commented on the need for regular support including on the job support everyday, but not all day.

breakthru perspective

breakthru as a community provider of mental health services adheres to the belief that social inclusion is being able to participate and be part of a society that genuinely welcomes and is inclusive of all people living with mental illness, genuine inclusion is a society that does not discriminate or stigmatise. The following views expressed by breakthru are underpinned by this belief.

Homelessness services

It may seem like a simple answer to solve the issue of homelessness; build more houses and fund the system better. With the size of the housing unmet need the economic impact is sizable. However, in order to truly break the cycle of homelessness, not only does housing need to be addressed, but the sentiments echoed above from clients within the system needs to be heard.

It is clear that the current system is not working. Last year 17,772 people who presented at homelessness services in Victoria cited mental health as one of the reasons they were seeking help (Council to Homeless Persons, 2019). This is a trend that extends across Australia with people who have a current mental health condition accounting for 28% of people requiring support from a specialist homelessness service, and they are also more likely to require support on multiple occasions (AIHW, 2018). Furthermore, significantly more people are in housing crisis and the available housing stock is shrinking. Housing shortage is a problem within the general population (Rowley, 2018) however this is made more difficult for people who find themselves in crisis and unwell trying to find housing.

One of the compounding factors with the housing problem is that the fragmented nature of support systems do not support people effectively. As a community mental health service we observe that housing access points are increasingly under resourced, under pressure and less responsive to other providers trying to assist people in need. One in four people are turned away from homelessness services due to this lack of resources (Council to Homeless Persons, 2019). The limitations of resources has a direct impact on individuals and support services ability to break the cycle. Consequently the response is a 'band aid' approach, not an early intervention approach with a focus on long term sustainable housing.

As a provider of case management services for people with mental illness who are homeless, we can see the benefits that sustained engagement can have. However with funding limitations, providers are under pressure to discharge people to avoid being fined, which inevitably takes precedence over the welfare of a person. How can a system create long term change when the needs of the people it is designed to support is not what is driving decisions?

Additionally the shortage of housing stock has created a waitlist which belies the urgency of the situation. People who are in crisis who have children simply cannot wait a few years for housing to be made available. Without a place to feel safe and a roof over their head, a person's mental health will never improve. They will not be able to build relationships, they cannot look after themselves, they cannot become involved in their community and they won't be able to increase their skills or have the resources available to find employment.

Challenges of workforce

In breakthru's experience the workforce used to deliver mental health services are qualified and respectful in their approach. However, some basic structural changes to funding could address some of the concerns highlighted in feedback received as well as help to integrate support across contracts and increase workforce productivity and attraction. In some cases we have seen the NDIS as an opportunity for early intervention workers (who are qualified) to use their qualifications in a clinical manner, for example as a registered counsellor or social worker under certain lines of funding under the NDIS. As it stands the complexity of funding in the mental health sector, with different rules around eligibility and accountability, prevent integration of workforce and creates a confusing landscape for participants.

While the transition from grant based mental health funding to the the NDIS has had some positive effects on workforce in terms of creating opportunity, there have also been other unintended negative effects. One of the more significant of these consequences is the migration of experienced mental health workers away from NDIS support or leaving the mental health sector altogether. The reasons behind this include increased pressures around productivity and billable support, with corresponding decrease in workers capacity for self-care that traditionally existed in the sector, leading to decreasing job satisfaction. Workers have also expressed disillusionment at the 'watering down' of qualifications and reduced pay expectations.

This has a direct impact on organisations who still have customers needing support from experienced mental health workers. While there is an increase of new graduates entering the workforce, consideration must be given to risk mitigation strategies around managing an inexperienced workforce with less resources. It also has broad ramifications on the sector at a time where there is increasing demand for workforce, including for mental health workers, in the NDIS. We need to be looking for ways of attracting more people to the sector, not pushing them away without relying too heavily on the informal carer network.

A matter of inclusion

In 2010 as Deputy Prime Minister and Minister for Social Inclusion, Julia Gillard defined the Australian Government's commitment to social Inclusion, stating it **"is about building a stronger, fairer nation in which every Australian gets a fair go at the things which make for an active and fulfilling life".**

Being socially included means that people have the resources, opportunities and capabilities they need to:

- Learn (participate in education and training)
- Work (participate in employment, unpaid or voluntary work including family and carer responsibilities)
- Engage (connect with people, use local services and participate in local, cultural, civic and recreational activities)
- Have a voice (influence decisions that affect them)

While this is good intention it is evident by our experience and the feedback given by our customer group that this is not as yet the case for all Australians. We have outlined throughout this feedback paper the challenges faced by people experiencing mental illness in participating in employment, accessing work opportunities, being fully included in the life of their community and having their voice heard.

In order for the non- government sector to better support people living with mental illness and help in the achievement of the principles on social inclusion we require greater resourcing and greater investment in community based supports. We need to improve the working relationship and coordination between hospitals and the range of community based supports available.

Limitations of education to support people with mental illness

While service providers and support workers are committed to achieve the best outcomes for people with mental illness, it is often the restrictions of the contracts and the lack of innovation within them that prevents this.

Limited resources in the education and training sector to provide individualised support for people with mental illness leads to a higher dropout rate. These limitations have a direct impact on providers capacity to accommodate training for people with episodic conditions through enabling flexible modes of learning and curriculum. While funding can vary from a federal or state perspective, overall trainers and educators are increasingly challenged when working with diverse needs within a group setting. Initiatives that have been trialled with one-on-one training and well resourced student support services, results in an individualisation of training and support that is more conducive to learning. However, there is no consistency in how support is provided, with RTOs and Schools managing this very differently based on their own limited resources, awareness, and understanding.

Understanding of mental health is limited amongst education and training providers. breakthru have had many students withdraw from face to face training programs in the past when they've experienced episodes of mental ill-health (due to personal circumstances) with health professionals advising them to cancel their enrolment. With training designed in a way that the class progresses together, when a student needs time off, the re-engagement itself can be overwhelming and must be managed carefully. In some cases, it's not viable with the funding available to assign a trainer to 1 on 1 time for students to catch up on missed learning.

While outside support may also seem like a possible solution, many students feel stigmatised and judged by the other students or they need to constantly explain their situation when they attend classes with a support worker in tow.

There are some good examples of cross-sector collaboration between providers of mental health, mainstream services and the community helping to alleviate the pressures of limited funding. One example is in the school system which is one of the main sources of referrals for the FMHSS program. This system is stretched due to the high caseload of school counsellors and limited days they spend at each school (e.g. sometimes only one day per week). The relationships built by the FMHSS team within the communities they work in have helped ease pressures on locals schools and in some case a support worker may be based at the school for entire day working with students.

Such early intervention programs, where structures of support are built within mainstream service systems, have shown to have enormous long term benefits for people.

Another example of in-school supports demonstrates these benefits. Between 2013 - 2016 the NSW Department of Aging, Disability and Home Care funded a program called the Transition Support Project which supported high school students with a disability to start the planning process for life after school, centered around their goals and aspirations. Periods of transition, like the transition from school to adulthood, hold many inherent challenges and uncertainties, and is a potentially volatile period for someone living with a mental illness or at risk of developing a mental illness.

The personalised transition plan developed for each participant looked at all areas of a students life including social, health, interpersonal (e.g. self esteem), security, recreational and vocational domains. Supports provided included but not limited to, mentoring, work experience, access to further education and training, build networks, links to community and social support. The outcomes achieved included work experience opportunities, paid employment, volunteer work, referrals to community supports, (e.g .Headspace), apprenticeships / traineeships and ongoing engagement in school until the end of year 12. Unfortunately this program is no longer funded, with many of the students who accessed the service not being eligible for NDIS, this is an example of an early intervention service that was in high demand no longer being available.

Limitations of employment support for people with mental illness

It is clear from Australia's track record with employment for people with disabilities, and mental illness specifically, that the employment service system could be vastly improved in delivering better employment outcomes. Australia ranked 21st out of 29 OECD nations in 2010 when it came to employment rates for people with disability, with this rate declining since 1990 (OECD 2010). In 2011-12, 62% of working age Australians with a mental illness were employed, compared to 80% of those without a mental illness (DHS 2013).

We would like to highlight two examples of the structural challenges that exist in current employment program practice.

1.   Matters of eligibility. For people who experience mental ill-health, the manifestation of their illness varies from person to person. Mental illness can vary in severity and be episodic or persistent in nature. The resulting level of disability requires different levels and approaches in support. Contemporary approaches to mental health recognise that the majority of people with episodic mental illness can be expected to recover with appropriate support and treatment (NMHC 2012). Further, the effectiveness of interventions is directly related to the timeliness of support. However, it is this group of people that either 'fall through the gaps' due to strict rules of eligibility in funded programs (like the NDIS and DES), who receive inadequate support or receive support after a protracted application period, thereby negating the potential positive benefits of early intervention support.

2.   Contract generality. While breakthru embraces the modern outcome-focus of contract funding, this can often act as a blunt instrument and lacks specificity for different participant cohorts. Within this environment, the workforce traditionally doesn't have the skills or knowledge to build the capacity to employment of a person with mental illness. For example, with Disability Employment Services the focus is on speed to education or employment placement. Whilst speed to placement is an important indicator of achieving an employment outcome, it can ignore the importance of concurrent pre-vocational support which can ensure the sustainability of the employment. As we have experienced through the delivery of DES (psychiatric contract), when providers do adapt the service for a specific cohort, this leads to both lower 'performance rating' of services in an otherwise well performing program and a less individualised approach. Rather than providers tailoring their support to the particular needs of people with mental illness, contract requirements act as a disincentive for providers to individualise.

The key driver that prevents an individual approach in the DES contract is lack of funding level consistency. The assessment process that determines the level of funding for individuals is inconsistent and flawed with people who really require a higher level of concurrent pre-vocational support missing out on this funding. The assessment process also affects employment benchmarks which are therefore inconsistent and don't reflect a person's support needs. With these elements underpinning the performance framework, this presents and conflict of interest for providers because performance and revenue may be seen as running contrary to the best interest of the participant, for both their achievement of sustainable employment and ultimately their mental health.

Societal attitudes and indirect discrimination

Despite significant progress in community awareness regarding mental illness in recent years, the stakeholder perspectives outlined above demonstrate that there is still significant discrimination and stigma around mental ill-health in Australia and that this is the single largest barrier to economic, civic and social participation.

Discrimination is systemic in the workplace and the community with people feeling that support in the workplace and protection under industrial law is lacking. Despite the prevalence of mental illness, with almost half of Australians experiencing some form of mental illness in their lifetime, there is a general absence of awareness and demystifying mental illness in the community.

A clear example of this is in the workplace where people with mental illness comprise some part of the workforce in the majority of businesses whether the employer is aware of it or not. However, many people feel that the very fabric of employment is not accommodating for people with mental illness and that misconceptions and stigma around mental illness are common. For example, while some isolated innovation exists around supporting people with disclosure conversation, there is little support or larger conversation around how this can happen.

Often the first time an employer is aware that an employee has a mental illness is when that person has a period of ill-health with absenteeism or difficulties in the workplace, leading to a loss of that job. While we feel disclosure is a personal choice of an individual, the current situation in the workplace (and in other community settings) means that people feel they don't really have a choice and they must keep their condition hidden for fear of discrimination.

Consequence of barriers

It is important to note both the broad impact of the above mentioned barriers to access and the very personal consequence to individuals including unemployment, under employment and statistically lower income threshold for people with mental illness, resulting in lower living standards and social connectedness in the community. Given the high proportion of people living with mental illness in Australia, 20% of the population in any given year, this has a significant impact on productivity and the cost to the economy, estimated in 2016 at $60b annually (4% of GDP), including direct costs of the use of health and other services and indirect costs due to lost productivity.

Concluding comments

This submission to the Royal Commission into VIctoria's Mental Health System considers a variety of perspectives including those from jobseekers and participants of the NDIS and community mental health programs, carers and families, support workers and breakthru subject matter experts. Although the views from each group are unique, there are common themes that are summarised in the concluding comments and recommendations below.

What does the problem look like?

The stakeholder perspectives reviewed in this paper provide insight to the barriers to access that people with mental illness face. These barriers fall into 2 main categories; the limitations connected with the formal support system and funding parameters and the stigma and discrimination that exists generally in the broader community. Below is a summary of the key problems identified and shared by the collective stakeholders.

1.   Discrimination towards people with mental illness is prevalent in Australia, it is systemic in the community and denies people access to the same rights and opportunities as the general population. This discrimination extends to the all various domains of life, including through education and employment. This discrimination can present as active and explicit (unequal treatment) or passive and covert which includes an unconscious and unintentional bias against people with mental illness. This deeply imbedded cultural bias is what previous Disability Discrimination Commissioner, Graeme Innes, has often referred to as "the soft bigotry of low expectations".

2.   Employers are members of the community, so it is no surprise that employers reflect the prevailing negative attitudes of the general community towards people with mental illness. Despite the prevalence of mental illness, community education, awareness and capacity building strategies are limited, including for employers and workplaces.

3.   Stigmatisation and the fear of difference was a very real motivating factor for people with mental illness to not engage in the community or economic participation.

4.   Funding limitations, including eligibility and lack of resources, means there exists a sizable gap of services in support, including housing, education, employment and community mental health services.

Complexity of funding inherent in the system also contributes to the gap in services. People simply don't know what support is available, or what the objectives of services are, or how to access them, or where to even start. Part of this is the general confusion that exists around the dual system that exists between state funded services and commonwealth funded NDIS. This runs contrary to the intent of the NDIS which was first conceived to overcome the 'confusopoly' of the previous disability system as first described in the Productivity Commission report Disability Care and Support, (2011).

5.   Funding generalisation in education and employment services has also prevented the creation of tailored and individualised support for people with mental illness.

Recommendations

Amongst the feedback received from stakeholders, it was agreed that the biggest challenge was to change cultural attitudes and stigma towards people with mental illness. However large the problem, stakeholders also recognised that a shift in attitudes had already begun. Awareness of mental illness in recent years, with prominent people in the community speaking openly about their own lived experience of mental illness, has had a positive de-stigmatising affect, although it was recognised that there was still a long way to go.

Until a person with mental illness can live in the community without feeling stigmatised, while being fully supported by that community, there will be room for service providers to continue fighting for people to be afforded the same opportunities as everyone else. A fully inclusive Australia is still decades away, highlighted by the fact that segregated settings still exist, like Australian Disability Enterprises and specialist schools settings, rather than people receiving all the supports that they need from mainstream services and the community.
Some of the recommendations that offer potential solutions to the problems listed above and create pathways for people to achieve economic and social outcomes are:

Recommendation 1: Supporting the mental health workforce

- Mental health workers are susceptible to fatigue and burnout directly related to the support they provide. Funding policy should recognise that self-care is an important component to enable resilience in our workforce and ensure they remain in the sector.

- While pay isn't the only motivator for workers, it is an important incentive to attract and retain people in the industry, as is ongoing training and development. Funding must ensure salary and career progression are accounted for in any financial modeling of services.

- Boosting supply of mental health workers is paramount to the growing demand for services. As a sector, we should be looking to other industries and universities to attract workers to the industry including men, but also nurturing our informal carer network to include free access to education and supports for both themselves and the person they support.

Recommendation 2: Building community capacity

- In order for the non-government sector to better support people living with mental illness and help to achieve impact towards the principle of social inclusion, we require greater resourcing and greater investment in community based supports. We need to improve the working relationship and coordination between hospitals and the range of community based supports available.

- We need to work harder and smarter in changing community attitudes to mental illness. This can be achieved through media campaigns that aim to reduce the stigma and myths about mental illness.

- Additionally, more widespread education and capacity building of employers is required, including support for co-workers and workplace adjustments, including providing flexible working arrangements for people with episodic conditions. A systemic approach to support or protect people industrially in the workplace when people experience mental ill-health is also required.

Recommendation 3: Increasing knowledge and options for people living with mental illness

- Better education and information for people living with mental illness to understand the possibilities and opportunities through the NDIS is needed. We have heard some of our participants talking about wanting access to drop in centres again and missing the social interaction they had at a drop in centre. breakthru believes this in indicative of the intent of the reform not being fully realised as yet. We want people living with mental illness to be able to "drop into their community" not be reliant on drop in centres for people with mental illness. To achieve the intent of the mental health reform we need to build the capacity and understanding of people living with mental illness, clinical, community teams and society.

Recommendation 4: Change policy for homeless services

- Hospitals (in particular psychiatric hospitals), prisons and PARCs to not discharge people into crisis accommodation, onto a friends couch or rooming houses due to the pressure of a bed shortage. Discharging to inadequate accommodation perpetuates the cycle of mental illness.

- Consideration of decentralising the intake process for homelessness services. The current central access point for housing is not working. The demand is increasing (Council to Homelessness Persons, 2019) however the resources funded by government is not keeping up.

- Real Estate agencies to be mandated to consider applications from community agencies on behalf of clients. A quota per month to be set.

- A PARC type facility for people released from prison.

- An audit of the government housing stock and the way the system is managed.

- Regulate private rooming houses better. While rooming houses are used as a place of last resort, the potential risk of deterioration of mental health or violence is high.

- Re-instigate the successful Victorian government funded Supported Housing Outreach Program for people with a psychiatric disability and replicate nationally.

- With a shortage of housing for people with children, more housing stock that is suitable for families and transitional housing stock to accommodate more families is required.

- Motivating the community and general public to assist with the problem. An advertising campaign seeking support and highlighting the issue would generate innovative thinking and support. Big business are already investing in increasing social housing stock (Pro Bono Australia) and capitalizing on that desire from the general public to help.

Recommendation 5: Change policy for education and employment support

- Build more flexibility in training around completion timing and funding around providing support during periods of ill-health or streamlined referral to support services.

- Students also benefit from broad social adjustments to the campus style of teaching. Alternative learning modes should be made available for people who feel they are not suited or comfortable in campus environments such as virtual classrooms, smaller tutorial groups, etc.

- Better resourcing for people to provide one-on-one support when needed, and training for educators. Additional support may be supplementary to the study topic and include practical strategies to maintain motivation, time management, stress, reinforcement and memory.

- More extensive use of early intervention transition programs in schools and other mainstream service systems.

- Creating easier pathways for disclosure of mental health support needs in education and employment by using supported disclosure techniques. Using strengths based approaches like the Managing Personal Information (MPI) (Waghorn 2010) framework to support the disclosure discussion with employers (and educators) has the potential to raise awareness, reduce stigma and assist jobseekers to maintain employment or education.

- More leadership from government in employing people with mental illness would help improve the labour participation. Government are large employers and should lead by example in the hiring and promoting of people with mental illness.

- Design employment programs that cater specifically for people with mental illness and do not penalise providers that support them. While still focussing on employment outcomes, the Employment Services system must look at innovation and a consistent approach to supporting people with mental illness. We need to take a more coordinated and streamlined multidisciplinary approach so that people are not continually moved around different service systems. We can look to combine the best elements of the programs currently available: the individualised and holistic nature of PHaMs with its focus on early intervention support and recovery, together with the employment focus and employer networks of DES. Insurance models like the NDIS have also demonstrated that choice and flexibility for participants within the program is an important step in recognising individual agency to determine the best support for them to achieve employment goals. While choice exists in DES in a limited way, overseas examples in the US, the Netherlands and Germany have shown this has a powerful positive affect in people looking for work.

- Practical and experiential work experience and effective vocational assessment and job matching. These strategies have shown to not only help identify employment quickly, but to also ensure that the job is a good fit for the job seeker and promote job sustainability.

- Strengthen both the incentives for employers and their obligations. Employers should be encouraged and obliged to provide accommodating employment environments and conditions (e.g. flexibility with employment conditions like leave, reasonable support and adjustments). Encouragement can be financial incentives like tax breaks, subsidies and emphasising the benefits of providing an accommodating environment.

- Incentives could appeal to business ability to promote their credentials as an inclusive employer. An good overseas example of a broad diversity index is the U.S. disability equality index which rates businesses on their disability inclusivity policies and practices on a scale from 0 to 100. The index incorporates a range of criteria, including culture and leadership, community engagement, employment practices, and support service. An index provides a benchmark for business to be accommodating for all people with disability and also provides the evidence that hiring people with disabilities and having a more inclusive culture actually made business sense.

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