Wellways Australia submission to the Victorian Royal Commission into Mental Health

July 2019

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Executive Summary

The ineffectiveness of Victoria's mental health system, fragmented and dominated by a medical model, has major adverse impacts – with increased experiences of isolation and indifference for people who experience poor mental health, their families and carers.

To reverse this requires a fundamental reframing of the ways in which we all relate to one another. Wellways Australia believes in building inclusive communities – ones in which everyone has the opportunity to lead meaningful and satisfying lives and participate as fully as they would like as valued members. Inclusive communities celebrate diversity and understand the strength that this diversity brings to the community as a whole. Inclusive communities challenge age-old prejudices and the established patterns of discrimination they foster, replacing marginalisation and isolation with affirmation, eager welcoming and embracement.

This is a powerful vision of the future, particularly for many groups who have been disenfranchised and marginalised – cultural, sexual, and ethnic minorities and indigenous communities in particular – and thus it calls for a new generation of policies, programs, and practices that consistently engage us all. But for people with mental health issues – psychosocial disabilities, sensory, cognitive, developmental, intellectual, or emotional – the evidence regarding community inclusion suggests the need for a still more significant shift. This encompasses the expectations people with mental health issues have for their own lives and their roles in the broader community; and in how society thinks about people with a lived experience of poor mental health and their right to be part of everyday life.

Wellways Australia supports the adoption of three broad theoretical paradigms that provide a useful framework for the emerging consensus around community inclusion: 1) human rights; 2) economic and moral development; and 3) individual health – all of which will help to shape the next generation of policies to encourage and establish a Community Inclusion Model of Care.

These paradigms provide a substantial framework and grounding for an increasing emphasis on community inclusion and implementation of a new generation of policies, programs and practices that promote participation of those with disabilities in the community. This includes an emerging commitment among all members of society to seek out, welcome and embrace individuals who have typically been excluded is the vision of the future.

These paradigms, combined with existing rehabilitation frameworks and evidence from the field of mental health, lead to 11 fundamentals that can serve as a blueprint for the future development of much needed health reforms in Victoria.

Wellways has chosen to focus on five questions posed by the Royal Commission:

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

5. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

7. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

10. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

These questions have been substantially responded to not directly, but indirectly throughout the submission.

Key to Wellways Australia's submission is that Victoria must give mental health the same priority as physical health. This phrase perfectly captures Wellways Australia's ambitious aim to mainstream mental health in Victoria, and across Australia. Our position is clear. We expect both equity and parity of esteem between mental health and physical health services.

The solution to the State's failure to adequately provide a mental health system is not just a question of money. Success of mental health policy should be measured by the State's wellbeing, not just by levels of public funding. We need a Victorian-first public health strategy that will give equal weight to both mental and physical health.

Peer work is at the heart of many Wellways programs, from our peer support Helpline to social and housing support. It is also the source for an emerging workforce in a sector which has both rising demand and a chronic shortage of trained workers. Economic modelling indicates that a peer workforce can deliver a return on investment of $3 for $1 invested.

At Wellways, we understand that in order to return to overall health, people need to return to and be supported in the community in which they live. People cannot recover long-term good mental health in isolation. To achieve this requires a fundamental reframing of the ways in which we all relate to one another. This is why it is important to build inclusive communities – ones in which everyone has the opportunity to lead meaningful and satisfying lives and participate as fully as they would like as valued members.

Increased opportunities for association result from engagement in conventional, community-based activities as an individual, with friends and family members of one's choosing or with strangers who may become friends. Wellways recognises the issue here is one of opportunity. People can choose separation for a variety of good reasons, but a focus on community inclusion requires that individuals have many options to choose from.

About Wellways Australia

- Established in Victoria in 1978
- 1,850-plus staff across over 100 offices throughout Australia's eastern states: the Australian Capital Territory (ACT), New South Wales, Queensland, Tasmania and Victoria
- 240 people working in peer support roles
- 189 volunteers contributing over 14,000 hours
- Our services reach thousands of people every year

Wellways Australia is a provider with 41 years' experience. We specialise in mental health and disability support. We dedicate resources to advocacy, to ensure systems are responsible and equitable, and society is inclusive. To us recovery means all Australians lead active and fulfilling lives in their community.

We work with individuals, families and the community to help them imagine and achieve better lives. We provide a wide range of services and assistance for people with mental health issues, disabilities and those requiring community care.

Our Vision is for an inclusive community where everyone can imagine and achieve their hopes and potential. The four pillars of our work are:

1. Community inclusion is as important as treatment;
2. We create opportunities for connection with a diverse range of people;
3. We ensure community supports are accessible to everyone; and
4. We challenge barriers to inclusion, such as poverty, discrimination and inaccessible environments.

This philosophy underlies the many direct services we deliver to thousands of people each day across the Australian eastern seaboard. The following terms are the tenets on which Wellways services and programs are based.

Terminology

Community-managed non-government organisations (CMOs/NGOs)

CMOs are not-for-profit community sector organisations managed by a board of elected community members. NGOs are private organisations which may be not-for-profit or for profit. In this submission, the acronym CMO is used unless otherwise stated as this is the focus of this submission, e.g. when referencing publications where other terminology has been used by the original source author.

Consumer / client / carer / participant / service user

In this submission the term 'consumer' has been used to refer to people who access and are supported by CMOs although the terms 'person', 'client', 'service user' and 'participant' are referred to by many in the sector. These differences are based on sector history, the policy environment, traditional service models and the emergence of new approaches to language.
This change includes a shift from the use of medical model language, towards recovery-oriented language - a language that reflects hope and optimism. The adoption of recovery-oriented language has not been uniform across the sector.

In this submission, the term 'carer' has been used to describe the (unpaid) people who care for and support people who experience mental health conditions. A carer may be a family member, friend or other chosen person.

Person-centred community care

Wellways provides 'person-centred', individual care in communities where people live. Key to this is encouraging relationships and connectedness, fostering hope, promoting physical health and supporting self-management, that enable people to remain at home.

We focus on connecting people to natural supports, enhancing opportunities for people to connect with others in their local communities. We work with people in a flexible away according to their need, drawing on existing services and programs available.

Our work is based on evidence of what works, delivering proven services and supports with measurable outcomes. We support people to manage their mental health, so they can live and thrive at home, instead of requiring episodic, emergency medical assistance.

The challenge is that the conventional system is dominated by the medical model to the detriment of rights and quality of life. Building more psychiatric wards is not the solution to rising mental health issues in Victoria. Instead, it means addressing fundamental issues such as housing, support, jobs, education and meeting basic rights. Addressing and ending endemic stigma and discrimination are also a vital part of the picture. A medical approach may not always look at the complete situation. We see the individual, their family and the community, not just the illness.

What is 'psychosocial disability'

> If disability is one of the great human rights challenges of this century, then within this, psychosocial disability remains one of the most challenging and misunderstood.
>
> - Paul Deany, from the International Disability Rights Fund

Psychosocial disability is an internationally recognised term under the United Nations Convention on the Rights of Persons with Disabilities, used to describe the experience of people with impairments and participation restrictions related to mental health conditions. However, it is not a term Wellways has conventionally used.

People with 'psychosocial' mental health issues may experience episodic and recurrent ill-health. They often lack support in several areas of their lives.

The term is now in greater use in Victoria and across Australia, largely due to the introduction of the National Disability Insurance Scheme. According to the NDIS definition: "Psychosocial disability is a term used to describe a disability that may arise from a mental health issue.

"Not everyone who has a mental health condition will have a psychosocial disability, but for people who do, it can be severe, longstanding and impact on their recovery. People with a disability as a result of their mental health condition may qualify for the NDIS."[1]

[1] National Disability Insurance Agency (NDIA), *Mental Health and the NDIS* (2019) <https://www.ndis.gov.au/understanding/how-ndis-works/mental-health-and-ndis>.

Key Assumptions

In Victoria many people with mental health issues no longer have access to the critical services they require. Without help and support, they risk becoming marginalised within the very communities in which they live, with many facing the possibility of not meeting their basic needs; a job, a connected community and a roof over their head.

Since 1978, Wellways has been an advocate for increased funding to support Victorians experiencing mental health issues and to close the funding gap between clinical mental health interventions and non-clinical, community managed mental health services.

Throughout our 41-year history, Wellways has witnessed Victoria – having been the model for deinstitutionalisation and community-based preventative care – become a State where chronic underfunding over the past two decades has seen Victorian investment in mental health fall well below that of the rest of Australia, with access to services at 39 per cent below the national average.

The current mental health system is failing Victorians experiencing mental health issues, their families and communities, both in metropolitan Melbourne and throughout rural and regional Victoria. Under successive governments Victoria has moved from having the best funded mental health system in Australia to the worst.

Critically, what is required are support structures that are designed to help people to live well within their family, relationships and the broader community, to have a safe home, to live lives that are as healthy as possible, to have control and choices, and to support recovery from grief and trauma. This requires the needs of consumers and carers to be at the centre of the design of the Victorian mental health system – and for consumers and carers to co-design his system.

Addressing severe and persistent mental health issues requires a complex system of treatment, care and support, requiring the engagement of multiple areas of government, including health, housing, income support, disability, education and employment. The government, as well as the non-government sector, deliver programs for people with mental health issues and their carers. However, building the architecture to support a cohesive mental health system is a challenging task.

This task becomes more challenging when each year 1.2 million adult Victorians, (one in five adults) will experience mental health issues and nearly half of the Victorian adult population (45 per cent) will experience mental health issues at some stage in their life.[2] Moreover, mental health issues now account for 13 per cent of the total burden of disease across the State, making it the largest single cause of disability, comprising 24 per cent of the burden of non-fatal disease. Furthermore, around 3 per cent of the State's adult population or 151,759 Victorians each year experience severe mental health issues[3] and approximately 18,000 Victorians have enduring and disabling symptoms requiring in-community, multi-agency support needs.[4]

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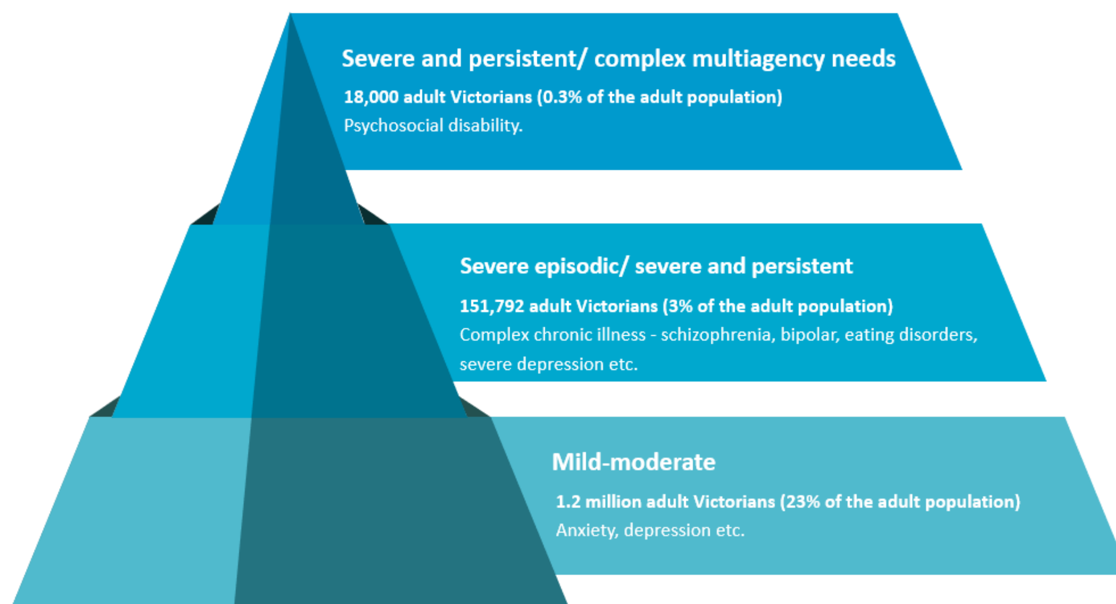
[2] Victorian Department of Health and Human Services, *Victoria's 10-Year Mental Health Plan* (2015) 7.
[3] Based on Victoria's adult population of 5.06 million in the June 2018 quarter. Australian Bureau of Statistics (ABS), *Australian Demographic Statistics, June 2018* (2018).
<https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3101.0Jun%202018> and Department of Health. *Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programs and Services* (2015) 25.
[4] Productivity Commission. *NDIS Costs Study Report* (2017) 31; National Mental Health Commission, *Contributing lives, thriving communities: Report of the national review of mental health programmes and services* (2014) 20.

Table 1: Annual distribution of adult mental health in Victoria (June 21018)
Spectrum of mental health issues in Victoria



Previously available support pathways to these cohorts are rapidly being decommissioned and government funding has been withdrawn from the very programs that have supported the majority of Victorians living with both mild to moderate and severe episodic mental health issues in order to fund programs under the National Disability Insurance Scheme (NDIS); programs only available to a greatly reduced number of people with a lived experience of mental health issues.

Consequently, in the four years to 2016-17, mental health related emergency department admissions have increased by more than 19 per cent in Victoria, and in 2019 there is a mental health emergency department admission in Victorian hospitals occurring every 10 minutes.

The truth of the matter is Victorians with mental health issues need certainty of support and access to effective and appropriate services. Feedback from a joint Wellways Australia and Mind Australia (Wellways/Mind) public consultation process, conducted over the months of May and June 2019, and included 5 public consultation workshops in metropolitan, rural and regional locations throughout Victoria, as well as publicly accessible online survey, has highlighted multiple deficiencies within the Victorian mental health system.

Joint Wellways Australia and Mind Australia Public Consultations

"Your Voice" Consultation Workshops

Wellways Australia and Mind Australia ran a joint public consultation process, entitled Your Voice – a series of six consultation workshops providing Victorians with a lived experience of mental health issues an opportunity to have their story heard and their lived experience contribute towards the Wellways and Mind submissions to the Victorian Royal Commission into Mental Health.

Insights and ideas shared by respondents have been incorporated into this submission to the Royal Commission, including the shared goals of respondents for the future of Victorian mental health system, and general health and wellbeing in Victoria.

Mind and Wellways held five consultation workshops across the State:

- Abbotsford - 22 May, 2019
- Geelong - 24 May, 2019
- Warnambool – 28, May 2019
- Box Hill – 30, May, 2019
- Frankston – 3 June, 2019

"Your Voice" Online Survey

Concurrent to the period Wellways and Mind ran the joint public consultation process, the two organisations also conducted a joint online survey. The online survey was made available to Victorians unable to attend a Wellways/Mind consultation workshop in person.

The following five questions were asked:

1. Thinking about mental health services that you have used, what has worked well?
2. What is the biggest challenge that you have faced with mental health services and what changes are needed to address this challenge?
3. How could services work better together? This could include mental health services and how other services that you might use, including GPs, government, housing, justice, legal to name a few.
4. What most needs to be changed to mental health services to better support you? Is there anything else important that you would like to share on the Victorian mental health system and mental health services?

Victorians with a lived experience of mental health issues throughout the consultation workshops spoke of the dramatic loss and disruption of services for Victorians living with severe episodic and persistent mental health issues. These include:

a. CMO services supporting recovery.
   This includes a diverse range of services and programs delivered by those with expertise in mental health issues (both through qualification and training, and through lived experience such as peer workers) and worked in a recovery-focused way to engage with and support people over time, to build capacity and to facilitate self-directed, strengths-based ways of living with and managing their mental health issues. These recovery-focused services were provided by the non-government or CMO sector.

b. Peer support and peer-connection.
   A gap repeatedly lamented by respondents was the loss of programs that enabled them to meet and spend time with other people who shared a lived experience of mental health issues. These lost programs created opportunity for, or supported people to, connect with and learn from others with a living/lived experience of mental health. The Wellways/Mind consultations repeatedly heard of an increase in isolation and a reduction in opportunities for connection and community building, supported by peers with similar experiences to themselves.

c. Preventative Care Model
   Due to the reduction in recovery-focused and peer-supported community-based pathways for Victorians with a lived experience of mental health issues, respondents participating in the Wellways/Mind consultations reported an increased use of and reliance on acute and clinical services. With the reduction of community-managed mental health sector services available

to support people to maintain their mental health or to recognise and anticipate early signs of relapse, support has only become available after a person has relapsed and become acutely unwell and in need of clinical intervention.

d. Carers
Families and carers, young and old, often receive limited help and too often report that they are ignored by health professionals on grounds that they need to protect the confidentiality, and respect the wishes, of people living with mental health issues. Respondents expressed their views that families and carers, including children, have detailed knowledge and insight and are often best placed to advise health and social care agencies about what may help or hinder the recovery of the person for whom they are caring.

e. Stigma and Discrimination
Bricks and mortar facilities, built in good faith to house and facilitate centres focused on mental health rehabilitation, have the ability to perpetuate and entrench stigma and discrimination. Respondents reported experiencing discrimination when entering or exiting buildings clearly identifiable as mental health facilities or organisations with links to mental health services. With an increased government preference to collocate health and mental health services in buildings or within a defined geographic campus, the rate of stigma experienced has substantially increased. Respondents reported experiencing a lower rate of stigma and discrimination when attending services provided within the general community and part of mainstream living. The stigma attached to poor mental health and the social barriers that surround it amplify its direct effects and damages the life chances of people with mental health issues. However, to shift public attitudes substantially, respondents recognise that this will require a major and sustained social movement across multiple sectors of the general Victorian community.

One of the most consistent themes fed back through the Wellways/Mind consultations has been that care for the most vulnerable Victorians with severe episodic and persistent mental health issues is not adequately integrated or coordinated, and people with complex needs often fall through the resulting gaps, creating a missing middle within the Victorian mental health system.

There is clear evidence that the State's growing dependence on clinical and acute supports is a direct consequence of the method through which the State has determined its funding contributions to the National Disability Insurance Scheme (NDIS). The State has chosen the more expensive, reactive and clinical pathway, rather than embracing the preventative, peer-supported and health-promoting pathway.

Give Mental Health the same priority as Physical Health

We must give mental health the same priority as physical health. This phrase perfectly captures Wellways Australia's ambitious aim to mainstream mental health in Victoria and across Australia. Our position is clear. We expect both equity and parity of esteem between mental health and physical health services.

The challenges are enormous but the rewards of meeting them are great. At least one in five of us will experience a mental health issue at some point in our life, and around half of people with lifetime mental health issues experience their first symptoms by the age of 14 and three-quarters by their mid-20s.

By promoting good mental health and intervening early, particularly in the crucial childhood and teenage years, we can help to prevent mental health issues from developing and mitigate its effects when it does. Wellways appreciates that successive governments have invested in a strategy to lay down a life course approach to mental health, recognising that the foundations for lifelong wellbeing are already being laid down before birth, and that we should do as much as we can to protect and promote wellbeing and resilience throughout the developmental and early years of life. However, there is a missing middle that requires support, the gap from adolescence into adulthood and then on into a healthy old age. Providing effective adult mental health support prevents episodic illness from becoming entrenched disadvantage and chronic disability. Only a sustained approach across the life course will equip us to meet the social, economic and environmental challenges we face and deliver the short- and long-term benefits we need.

Building inclusive communities recognises that our mental health is central to our quality of life, central to our economic success and interdependent with our success in improving education, training and employment outcomes and tackling some of the persistent problems that scar our society, from homelessness, violence and abuse, to drug use and crime.

Successive governments have expressed their intention to improve existing services for Victorians with poor mental health and to tackle the wider underlying causes of mental health issues. However, the evidence of their commitment is underwhelming and outcomes for Victorians with mental health issues disturbing, with governments preferring to introduce and operate programs in isolation from each other, while failing to adequately articulate how they would deliver improved services at the community, local, regional and State level to give all Victorians better mental health outcomes.

The solution to the State's failure to adequately provide a mental health system is not just a question of money. Success of mental health policy should be measured by the State's wellbeing, not just by levels of public funding. We need a Victorian-first public health strategy that will give equal weight to both mental and physical health.

Social inequality of all kinds contributes to mental health issues, and, in turn, a lived experience of mental health issues can result in further inequality – for example worse outcomes in employment and housing for people with mental health issues. When mental health services don't work, they can fail our Aboriginal and Torres Strait Islander communities and our culturally and linguistically diverse (CALD) communities, our young people who don't have stable family backgrounds and many others. Victorians with severe mental health issues die on average 20 years earlier than the general population.

But when mental health services work well, and work well with local public, private and voluntary sector and Community-Managed Organisations (CMOs), they help people to overcome disadvantage

and fulfil their true potential, strengthen our communities. That is why Wellways is advocating to give mental health the same priority as physical health. This fills a vacuum that exists in both public mental health policy and social justice strategies to support Victorians with a lived experience of mental health.

First, to give mental health the same priority as physical health, Government must demonstrate its commitment and do the things that only the Government can do – but it cannot deliver these ambitions in isolation. Wellways believes we all have a part to play to meet the social and economic challenge posed by mental health issues, and to improve the wellbeing of the Australian population. This will require a commitment across all State government departments, employers, schools, and local governments, as well as the voluntary and CMO sector and the broader community. Such cross-cutting strategies recognise that the Government can achieve more in partnership with others that it can alone, and that services can achieve more through integrated, pathway working than they can from working in isolation from one another.

Second, the expansion of choice and control. We recognise that this is vocabulary used within the National Disability Insurance Scheme (NDIS), yet it is particularly relevant to mental health, with Victorians choosing to take more control over their lives and build more capable communities. We want more decisions about mental health taken locally in the very communities in which people with a lived experience of mental health issues live, with more flexibility for Victorians to make decisions based on local needs.

At Wellways, we understand that in order to return to overall health, people need to return to and be supported in the community in which they live. People cannot recover long-term good mental health in isolation. To achieve this requires a fundamental reframing of the ways in which we all relate to one another. This is why it is important to build inclusive communities – ones in which everyone has the opportunity to lead meaningful and satisfying lives and participate as fully as they would like as valued members.

To achieve this a series of principles that should underpin much needed health reforms in Victoria are required, including:

- putting people who use services at the heart of everything we do – co-production and 'Nothing about me without me' should be the governing principles. Care should be personalised to reflect people's needs, not those of the professional or the system. People should have access to the information and support they need to exercise choice of provider and treatment;
- focusing on measurable outcomes and introducing quality standards that deliver consistent and effective programs rather than focusing on top-down output targets;
- empowering CMOs and practitioners to have the freedom to innovate and to drive improvements in services that deliver support of the highest quality for people of all ages, and all backgrounds and cultures. CMO support is a cost-effective intervention because it reduces costly hospitalisations and time away from work, while offering an Inclusive Communities Model of Care to build a team of professionals in the community and around a person experiencing mental health issues, including GPs, psychiatrists, peer support workers allied health professionals, housing, education and employment agencies; and
- building up a peer support mental health workforce to effectively engage people out of clinical care and in recovery back into the community, reducing the use of emergency rooms and hospitals, and reducing substance use among persons with mental health issues.

We know the conditions that foster wellbeing and prevent disability. We know many of the factors that help people to recover from mental health issues and live the lives they want to lead. We know the intersections between mental health, housing, employment and safe communities. Victoria requires a strategy built on this knowledge, which sets out ambitions the Victorian Government should share with its partners and against which it should be judged, and invites all Victorians to join in making better mental health for all a reality.

Recommendation:

Inclusive Communities Model (ICM) of Care

An Inclusive Communities Model (ICM) of Care should be established to provide coordinated support for people with severe and persistent mental health issues across Victoria to help them access local and targeted services.

The ICM aims to better support people with severe and persistent mental health issues, and their carers and families, by getting services and supports from multiple sectors they may come into contact with (and could benefit from) to work in a more collaborative, coordinated, and integrated way.

The objective of ICM is to improve the system response to, and outcomes for, people with severe and persistent mental health issues by:

- facilitating services to deliver 'wrap around' care individually tailored to the person's needs;
- strengthening partnerships and building better links between various clinical and community support organisations responsible for delivering services to the ICM target group; and
- promoting a community-based recovery model to underpin all clinical and community support services delivered to people experiencing severe and persistent mental health issues.

"In Community" support is a cost-effective intervention because it reduces costly hospitalisations, limiting exposure to stigmatising environments and time away from employment and support the emotional and economic wellbeing of both individuals and their families. The Inclusive Communities Model (ICM) of Care builds a team of professionals around a person experiencing mental health issues, including GPs, psychiatrists, support and peer workers and allied health, housing, education and employment agencies.

There is strong evidence that this type of model of care improves health. Economic modelling indicates that this intervention can deliver a return on investment of $3 for $1 invested.

Promoting Recovery

At Wellways, we understand that in order to return to overall health, people need to return to the community in which they live. People cannot recover long-term good mental health and build good lives in isolation.

Recovery in the community in a mental health context refers to the process of transforming the consumer's, their family, carer and community's attitudes to mental ill health. It is about living a full and contributing life without stigmatisation and any perceived limitations. Equally, this concept can apply to a mental health service system where the community support system is organised around the recovery model, rather than traditional medical paradigm.

Instead of each service examined in terms of improvements to impairment, dysfunction, disability and illness, a recovery-based mental health system assumes that recovery can occur at times without professional intervention and can happen with support from an outside person. Recovery can occur even though symptoms persist or recur. Such a system also assumes that recovery can change the frequency and duration of symptoms, and that recovery is not a linear process.

Community Inclusion

CMO services are a vital part of the mental health system, providing care in a community setting to people with severe mental health issues and psychosocial disabilities. CMO mental health services build resilience and provide early intervention when people become unwell, and support people to return to their community from more acute settings like hospital. Community support is a cost-effective intervention because it can help to reduce costly hospitalisations, limiting exposure to stigmatising environments and time away from employment and support the emotional and economic wellbeing of both individuals and their families.

This philosophy of community inclusion is based not just on our experience of what works, but also academic investigation and evidence. *Well Together: a blueprint for community inclusion,*[5] by Dr Mark Salzer and Richard Baron of Temple University, USA, was commissioned by Wellways Australia to build on our existing knowledge base and to ensure that the work we do, now and into the future, is firmly grounded in the best available and most contemporary evidence.

The report sets forth fundamental concepts, theoretical frameworks and evidence for community inclusion. It guides our practice principles to our work with people experiencing a range of disabilities and mental health issues. These include:

- Community inclusion is important: While high-quality treatment and rehabilitation services must continue to be available, there should be a prevailing understanding and emphasis on community inclusion among all stakeholders.
- Community inclusion requires seeing 'the person', not 'the patient': Each person should be accorded respect; seen by those around them – including disability service providers and community groups – as an individual with unique strengths, problems, interests and cultural identity; and never defined by their impairments or differences.
- Community inclusion should embrace multiple domains of conventional life: Each person should have the chance to pursue participation in areas that are important to them rather than being restricted by what is available or believed to be important by society.

[5] Salzer, M.S. and Baron, R.C., (2016) Well Together: a blueprint for community inclusion: fundamental concepts, theoretical frameworks and evidence, Melbourne, Australia.

- Community inclusion focuses on participation that occurs more like everyone else: To the degree desired by the person, participation should be self-determined, in the community, and should maximise opportunities for interactions with the most diverse group of fellow citizens possible.
- People should have access to supports that enables participation: Programs should promote awareness of community resources and develop skills to access these; they should provide supports to involve families, friends and carers; and offer peer support.
- Environmental barriers to community inclusion must be identified and addressed: Community inclusion initiatives should specify the environmental barriers to community inclusion – among them negative public attitudes, pervasive poverty, and inadequate public transportation – and adequately address them.

Community inclusion initiatives should work actively to engage people to participate in the ample conventional resources that are available to all citizens, connecting people to jobs and schools, clubs and teams, religious congregations and recreational programs used by everyone.

Community inclusion requires establishing welcoming communities. Community inclusion initiatives should work with community groups to help establish a welcoming and mutually supportive community, where an individual's participation is valued not only for their uniqueness, but also for the contribution individuals with disabilities can make to enhance their community.

Community inclusion requires a dramatic shift in how the rest of society thinks about the engagement of people with mental health challenges and psychosocial disabilities in the fabric of everyday life. This is a powerful vision of the future, particularly for many groups who have been disenfranchised and marginalised in the past, including people with physical disabilities.

These commitments, and the fundamentals required for making them a reality, are embedded in 10 fundamental principles of community inclusion expressed in Well Together.

The Well Together principles:

i. Emphasise and advocate for community inclusion as an equally critical intervention alongside treatment and rehabilitation
ii. Ensure opportunities for inclusion are available to everyone who experiences a disability, even if others believe they are "not yet ready"
iii. See people as unique individuals with strengths and gifts to offer, and not defined by their impairments
iv. Support people to take the lead in making choices and decisions about things that are important to them, including managing any risks that may be involved
v. Work with people to explore multiple areas of life and community spaces that interest them, not restricted by what others believe is possible or desirable
vi. Promote participation that happens in the same places everyone else in the community can access, and maximise opportunities for connection with others
vii. Offer evidence-based support technologies that enable participation including peer support, engaging family and friends, and natural support development
viii. Support families and natural supports to sustain their role, and to pursue wellbeing and inclusion in their own right
ix. Identify and address environmental barriers when working with people, including poverty, discrimination and accessibility issues

x. Work directly with community members and groups to establish welcoming and mutually supportive and spaces for all people[6]

Recommendation:

Reducing stigma and discrimination

Stigma and experiences of discrimination continue to affect significant numbers of people with mental health problems. This discrimination is damaging, unlawful and costly – for individuals, their families and carers, organisations, communities and society as a whole. Victorians with mental health issues have reduced opportunities in comparison to those without similar health issues. Part of this is the direct effect of their condition, but a very large part is due to stigma and discrimination, driven by ignorance and fear, and some people's negative attitudes directly towards them.

Stigma can also affect the attitudes and behaviours of clinicians, including mental health professionals. It can:

- stop people from seeking help;
- keep people isolated, and therefore unable to engage in ordinary life, including activities that would improve their overall wellbeing;
- mean that support services have low expectations of people with mental health issues, for example their ability to hold down a challenging job or maintain accommodation; and
- stop people working, being educated, realising their potential and taking part in society;
- result in all health issues of a person with mental health issues being viewed through a mental health lens, meaning physical health conditions are often overlooked and untreated.

Tackling stigma and discrimination and promoting human rights should be at the heart of the Victorian Government's consideration of a whole-of-government strategy to improve the State's mental health. Several CMOs currently undertake anti-stigma and discrimination activities, gaining additional benefit by encouraging Victorians with a lived experience of mental health issues to support and participate in their programs, thereby aiding their recovery.

However, Government has an important role to play by leading by example and providing a legislative framework that sets out the responsibilities of organisations and employers towards disabled people, including people with mental health problems.

The Victorian Government should make it a priority that fewer people will experience stigma and discrimination as a result of negative attitudes and behaviours towards people with mental health issues – to be achieved by improving public attitudes and reducing the institutionalised discrimination inherent in many organisations, including government departments and agencies, as well as support services.

[6] Well Together report available here: <https://www.wellways.org/about-us/publications>.

Peer Support

As a leading cause of disability and suicide with rising prevalence, tackling mental health issues requires a new, expanded response as the traditional medical model struggles to make headway. The Wellways experience, and evidence, shows there are better and longer-term outcomes when mental health support is addressed within a peer support model. This neatly fills the emerging gap in service provision for people with mental health issues, especially those who experience chronic and recurring mental health issues.

Providing peer services is one of the most effective ways of connecting people, strengthening families and transforming communities. Wellways recognises the central role a peer workforce plays in achieving recovery. Wellways uses a peer workforce in many roles not just in support roles, but across the organisation. We believe that people close to the problems of mental health are also closest to finding the solutions.

In New South Wales, peer workers are increasingly seen as holding a unique place in mental health services. In fact, the expansion of the peer workforce is one of the key reforms to come out of *Living Well: A Strategic Plan for Mental Health in NSW 2014 – 2024*.[7]

Living Well acknowledges the importance of peer work:

> We need to build a vibrant professional community mental health workforce that eases the pressure on acute crisis services and enables consumers to find care and support closer to home. Mental health services should be provided by a skilled, multi-disciplinary workforce that is supported by continuing education. New service models, based in the community, are emerging quickly and will continue to do so as the reforms set out in this Plan are implemented.[8]

Workforce planning needs to keep pace with these developments, and new approaches are required to supply the people and the skills to build a recovery-oriented mental health sector. An expansion of the present model will not be enough to meet the demands on the mental health system. We need a new way of arranging our workforce to make the most of their precious, professional skills.

This will require:

- the development of new workforce models, including the rapid growth of the peer workforce;
- strategies to ensure the most efficient use of the scarce specialist clinical workforce, including relieving them of non-clinical work; and
- the development of new service delivery and associated workforce capacity approaches grounded in community-based care and recovery-oriented practice.

To meet demand, we might also need to think more innovatively about what constitutes our workforce. As noted elsewhere, we need to better integrate and support GPs as critical components of our mental health system. But GPs are not always available and therefore the system must ensure the most efficient use of our scarce specialist clinical workforce, including relieving them of non-clinical work and delegating these tasks to a trained peer workforce.

As the Mental Health Commission of NSW states in its mid-term review of the *Living Well* Plan:

[7] NSW Mental Health Commission, *Living Well: A Strategic Plan for Mental Health in NSW 2014 – 2024* (2014).
[8] NSW Mental Health Commission, *Living Well: A Strategic Plan for Mental Health in NSW 2014 – 2024* (2014).

> "Peer workers play an integral role in supporting mental health recovery. Drawing on their lived experience of mental illness, or as a carer of someone with a mental illness, they provide support to others by working with individuals or families experiencing mental illness.
>
> Peer workers provide an expertise drawn from their own experience, which provides hope and models recovery for others who are mentally unwell.
>
> People with lived experience of mental illness fulfil many roles across the (NSW) mental health system, including management, education and research positions, as well as peer consumer and carer supports."[9]

There is compelling research showing that peer workers are effective and produce successful and measurable results in mental and general health care, including fewer hospital presentations and readmissions.

Peer services are generally just as effective as services provided by non-peer professionals. To date, multiple studies have found that those working in peer-specific roles are better able to:

- engage people in caring relationships;
- improve relationships between clients and outpatient providers, thus increasing engagement in non-acute and less costly care;
- decrease substance use, unmet needs, and demoralisation; and
- increase hope, empowerment, self-efficacy, social skills, quality of and satisfaction with life, and activation for self-care.[10]

For example, Professor Larry Davidson, Professor of Psychology in the Department of Psychiatry at the Yale University School of Medicine, states that research shows overall peers were found to be as effective as non-peers in providing services.[11] Some studies have also found a range of positive benefits of using peer support including reduced hospital use, and better engagement with care.

In the USA, Mental Health America data shows that around $3 in savings in hospital bed use is associated with every $1 spent on peer workers.[12] Similarly, data from six studies in the United Kingdom produced estimates of the number of hospital-bed-days saved per equivalent peer support worker in each study. Each study indicated that every £1 spent on peer workers correlated to savings in hospital bed use of £3. This in turn implied a net saving of £2 per £1 invested (i.e. gross savings of £3, less £1 spent on the peer support worker).[13]

Peer work is at the heart of many Wellways programs, from our peer support Helpline to social and housing support. Currently 30 per cent of the Wellways mental health workforce are peer workers. Peer work is also the source for an emerging workforce across our sector, which has both rising demand and a chronic shortage of trained workers.

Wellways recognises that there are dangers that the promotion of social capital may be a substitute for economic investment, particularly by those wishing to reduce government spending on welfare.

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[9] NSW Mental Health Commission, *Living Well: A Strategic Plan for Mental Health in NSW 2014 – 2024* (2014).

[10] Davidson, L., Bellamy, C. and Guy, K., 'Peer support among persons with severe mental illness: A review of evidence and experience' (2012) *World Psychiatry* 11(2):123–128.

[11] Davidson, L., Bellamy, C., Chinman, M., Farkas, M., Ostrow, L., Cook, J.A., Jonikas, J.A., Rosenthal, H., Bergeson, S., Daniels, A.S. and Salzer, M.S., 'Revisiting the Rationale and Evidence for Peer Support'(2018) *Psychiatric Times* 35(6).

[12] Mental Health America, *Evidence for Peer Support* (2018).

[13] Trachtenberg, Marija, Parsonage, Michael, Shepherd, Geoff and Boardman, Jed, 'Peer support in mental health care: is it good value for money?', Centre for Mental Health (2013).

However, for many peer workers it opens the door to a new career, particularly for those who have not had the opportunity of a formal education. In the Wellways experience this is an employment pathway as many volunteers with 'lived experience' of mental health issues eventually undergo training and transition to employment.

There are myriad personal and mutual benefits to this process, including:

- empowerment;
- connecting with others; and
- gaining work skills.

In addition to peer support, evidence-based peer support for carers is a crucial investment.[14] An estimated 60,000 Victorians[15] care for an adult with mental health issues. Wellways is also providing community support for carers to better cope and feel connected to the community in what can be an isolating role.

In working with people who experience mental health issues, research shows that peer support is effective as a complement to traditional services,[16] when peers work in traditional case management roles[17] and for people who are homeless,[18] as well as for carers.

For people living with chronic diseases and other health conditions, there is strong evidence that peer support is a critical and effective strategy for ongoing health care and sustained behavior change, and that its benefits can be extended to community, organisational and societal levels. Peers for Progress, a global network of peer organisations, conducted a review of a wide range of studies across the health sector and found that peer support:

- decreases morbidity and mortality rates
- increases life expectancy
- increases knowledge of a disease
- improves self-efficacy
- improves self-reported health status and self-care skills, including medication adherence
- reduces use of emergency services

[14] Farhall, J., Cugnetto, M.L., Mathews, S., Ratcliff, K., Farnan, S., Higgins, K. and Constantine E., Outcomes and change processes of an established family education program for carers of adults diagnosed with a serious mental health condition Psychol Med. (2019) <https://www.ncbi.nlm.nih.gov/pubmed/31030696>.
[15] Mental Health Victoria, *Saving lives. Saving money* (2018) 12.
[16] Clark, G., Herinckx, H., Kinney, R., Paulson, R., Cutler, D., & Oxman, E., (2000) Psychiatric hospitalizations, arrests, emergency room visits, and homelessness of clients with serious and persistent mental illness: Findings from a randomised trial of two ACT programs vs. usual care, Mental Health Services Research, Vol 2, 155-164.; Davidson, L., Shahar, G., Stayner, D. A., Chinman, M. J., Rakfeldt, J. and Tebes, J. K., (2004) Supported socialization for people with psychiatric disabilities: lessons from a randomized controlled trial, Journal of Community Psychology. Vol 32, 453–477; O'Donnell, M., Parker, G. and Proberts, M., (1999) A study of client-focused case management and consumer advocacy: the Community and Consumer Service Project. Australian and New Zealand Journal of Psychiatry. Vol 33, 5.
[17] Sells, D., Davidson, L., Jewell, C., Falzer, P. and Rowe, M., (2006) The treatment relationship in peer based and regular case management for clients with severe mental illness, Psychiatric Services, 57(8); 1179-1184.
[18] Dunt, D.R., Benoy, A.W., Phillipou, A., Collister, L.L., Crowther, E.M., Freidin, J., Castle, D. J., (2016) Evaluation of an integrated housing and recovery model for people with severe and persistent mental illnesses: the Doorway program. Australian Health Review 41, 573-581.

- leads to reduced depression, heightened self-esteem and self-efficacy, and improved quality of life for peer workers.[19]

Peer support can be highly effective in reaching people with mental health issues and psychosocial disabilities who may be alienated from, live in isolated locations or have poor access to health care. This includes people from culturally diverse communities, Aboriginal and Torres Strait Islander people, carers and people who experience discrimination relating to gender, sexuality and age and to experiences like homelessness, problematic substance use, and justice involvement.

Recommendation:

Peer Workforce Strategy

The government should establish a peer workforce strategy led by consumers and carers, in partnership with CMOs and specialist clinical mental health services and other relevant stakeholders.

The strategy should aim to identify and fund innovative roles for peer workers across the mental health system. It should aim to develop roles that support people to live in the community and have less reliance on acute services.

It should build on existing evidence and models e.g. Intentional Peer Support

There is strong evidence that the use of peers in recovery-focussed services is effective in assisting recovery.

[19] Boothroyd, R. & Fisher, E. (2010) Peers for Progress: promoting peer support for health around the world, Family practice, 27 Suppl 1.

Current and potential interventions to improve mental health outcomes

Homelessness programs

Wellways Australia's approach to housing is based on the premise that all individuals have the right to safe, secure housing and a place to call home. Having a home provides the foundations from which Australians can improve their physical and mental health, while also building community connections.

The existing system is at breaking point. Despite new housing and homelessness funding, Australia is not able to keep up with service demand resulting from social and economic factors such as housing affordability, domestic violence and substance misuse, as well as complications associated with mental health issues. In addition, sustainable housing options are limited. While there is a need for increased affordable housing for people experiencing homelessness, such an increase is only part of the solution. There is a need to embrace new options for housing such as private rentals or working with developers and industry to provide quality homes for individuals on low incomes that are in scattered locations.

An essential element to housing satisfaction and sustainability is choice about a person's needs in a home. Such fundamental needs may include location, size, ability to have pets, proximity to services and employment opportunities. Moreover, having choice about the home and community where you live provides individuals greater opportunities to build a sense of community and natural support networks, seek and secure employment and maintain a sense of 'ownership' which in turn supports successful tenancies. Combined with individualised support to build tenancy literacy and links to health services and community, more long-standing health and housing outcomes can be achieved.

For people experiencing mental health issues, support to prevent and respond to homelessness and accommodation instability, where homelessness programs include mental health support as part of an integrated program/team approach, mental and physical health outcomes are seen to improve. Through this approach, tenancy literacy is achievable for people with mental health issues – where support is provided to walk beside individuals in learning to how to maintain sustainable tenancy. Developing natural supports is a key component of long-term sustainability, especially as individuals who experience homelessness are less likely to have accessed the National Disability Insurance Scheme, where mental health support is provided, along with access to develop a plan.

Integration between services for housing, homelessness and mental health

Integration between services is essential to create a wrap-around support system for individuals, where the Housing First model provides the stability to support mental health outcomes. At present, where funding for mental health and homelessness is largely separate, Wellways recommends that mixed service stream programs, such as Doorway, are funded to break down silos and provide more integrated care options. Importantly, integrated teams with clinical mental health providers support a uniform approach to recovery and assist with linkages to homelessness and support services, as often the initial point of contact is with the hospital system.

Based on Wellways experience, housing support for people experiencing mental health issues who are discharged from institutions, such as hospitals, or correctional facilities needs to be 'assertive' outreach. This requires early identification of homelessness within the hospital and correctional systems to support referral and engagement prior to discharge, so individuals may be supported prior to and following discharge, limiting time in crisis shelters and emergency accommodation or rough

sleeping. Again, this requires integrated teams within the clinical and justice services who can provide family support and education, where this may be a factor that leads to homelessness.

Social housing requires flexibility to respond to the needs of people experiencing mental health issues. However, several factors currently impede the ability of social housing services to respond to these needs. These include:

- Housing stock and affordability for people on low income is limited and may not be in an individual's choice of town/ area to live;
- Long wait lists and priority levels impact on parts of the population's inability to secure social housing or to receive multiple bedroom units (i.e. single men);
- Inability to secure homes for future situations (reunification or visits with children) is not easily accessible through social housing; and
- Increased utilisation of the backdating mechanism to housing and support programs to assist those experiencing longstanding mental health and homelessness.

Other areas of the housing system to improve mental health outcomes:

- Programs which support capacity building of NDIS services to support early identification of at-risk tenancies and homelessness can support the stability of housing options. A Wellways NDIS Information, Linkages and Capacity Building (ILC) project, The Way Home, provides an insight into this important link;
- Building an evidence-based framework for homelessness programs that supports evaluation and innovation within the sector;
- Building a focus on individual health and community outcomes, including employment and education – that individuals with mental health issues can build healthy engaging lives; and
- Providing programs which can provide touch-points and different support levels: i.e. helplines and lived experience workers so supports are tailored to individual needs and information building.

Wellways Australia believes that our service system and funding models can be seamlessly integrated to support programs, such as Doorway, that will lead to an integrated approach to addressing homelessness. This will ensure that individuals can be easily identified, secure a home and build the structures and supports to enable full economic and community participation.

For 12 months, Doorway recovery workers assist clients in building social capital – learning how to navigate the private rental housing market, connecting with allied support services and health practitioners, learning 'return to work' skills, and developing confidence and self-efficacy in mental health issues management.

Doorway is cost effective as it interrupts and prevents the personal impacts of ongoing mental and physical health deterioration and disrupts social and economic consequences such as cycles of homelessness and poverty. It builds social capital and successfully supports people in finding work and making an economic contribution.

Doorway has been externally evaluated by the NOUS Group and The University of Melbourne. Both evaluations include an economic evaluation. The independent economic evaluation of the Doorway Program indicated governmental cost savings of $133 per person,[20] per day for people engaged in private rental through the Doorway program. This cost benefit analysis included economic costs

[20] NOUS Group, (2014) Formative Evaluation Report, Doorway Program, Melbourne

associated with utilisation of health, crisis and social housing systems being accessed by this population group, and others experiencing homelessness in the community.[21]

The result of this evaluation also indicated the average time in bed-based clinical mental health services per participant per year decreased from 20.4 to 7.5 days in the 12 months pre and post-housing – with the biggest decrease occurring with acute inpatient services (13.9 to 6.6 days). Furthermore, the preliminary economic evaluation of the current iteration of Doorway evidences greater cost benefits since the pilot with housing costs indicating a $3,688 cost saving to Government per participant annually. This is when compared to other social and public housing models.[22]

Evaluation of the Doorway pilot program indicated that 93 per cent of participants experienced significant improvements in housing security as well as in symptoms and behaviour, and there was significant reduction in hospital admissions (with a net saving per individual of over $3000 per year).[23]

Recommendation:

Housing First model

The Housing First model provides housing as a priority with the knowledge that without a stable home there is little hope of improvement in other areas of life, including health and mental health. Developed in the United States of America (USA) in the 1990s as a strategic response to homelessness, Housing First has achieved success in Australia, New Zealand, the USA, Europe and Canada.

Having a home where one is safe, secure and sustainable is the foundation to positive health, family and community connections, and Housing First has emerged with significant cost and health outcomes.

Documented randomised control trials of Housing First Programs have been run internationally and across Australia for people experiencing homelessness. The results of such trials indicate higher housing retention for people supported through Housing First support models, rather than traditional housing program models. This success offers strong support for the expansion of such housing models across Victoria to reduce homelessness.

[21] NOUS Group, Op Cit

[22] , D.R., Benoy, A.W., Phillipou, A., Collister, L.L., Crowther, E.M., Freidin, J., Castle, D. J., (2016) Evaluation of an integrated housing and recovery model for people with severe and persistent mental illnesses: the Doorway program. Australian Health Review 41, 573-581.

[23] For Doorway research, visit: <http://dx.doi.org/10.1071/AH16055>.

Addressing specific health concerns

Evidence tells us that for all people affected by mental health issues, when they are accepted and supported – rather than stigmatised – and they are welcomed to the community, they are much more likely to become active in employment, education, and social and physical activities. And they experience long-term recovery outcomes. But the reality is people with mental health issues are highly affected by stigma which seriously reduces their capacity to seek and engage help.

Stigmatising attitudes and false assumptions about mental health issues affect entire communities, individuals and families – preventing receipt of timely support. The most effective method in addressing these issues is community education, led by people with lived experience, the concept of 'contact'. Studies by Professor Patrick Corrigan of the Illinois Institute of Technology, USA,[24] have found that understanding and empathy increases substantially when opportunity is provided to learn directly from people who have a lived experience. When they have contact with, and hear a person's 'story' about mental health issues and recovery, their perspective shifts.

The Wellways Well Together community education program is based on Corrigan's research. Lived experience facilitators are trained to deliver the program. In 2017, ILC funding enabled Wellways to offer Well Together training to 5,042 people. They gained knowledge and skills in understanding, including and welcoming people with mental health issues. Evaluation of Well Together workshops demonstrated increased understanding and support.

Benefits of consumer and carer-led education programs include increased support, understanding and acceptance by family, friends and community. As a result, people with mental health issues are more likely to talk about what they are experiencing, seek support and access services earlier. Ultimately this leads to long-term mental health improvements as well as social and economic benefits for affected individuals. They have a greater likelihood of early recovery, and continuity of productivity.

Community education programs can be flexibly targeted to workplaces, community interest groups, Aboriginal & Torres Strait Islander peoples and non-English speaking communities, clubs and associations, religious groups and other organisations.

Facilitating social participation and inclusion

Wellways works at three levels to address social participation and inclusion:

- supporting individuals to claim their right as full citizens;
- strengthening families to be resilient; and
- creating welcoming communities.

A review of the literature on social inclusion in Victoria[25] suggests that policy aspirations in this area have yet to achieve much more than the "illusion of inclusion", with few real outcomes for people affected by disability and little guidance for organisations and practitioners on how inclusion might be practically and effectively implemented. The researchers noted several relevant critiques of social inclusion:

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[24] Corrigan, P.W., (2002) Empowerment and serious mental illness: Treatment partnerships and community opportunities Psychiatric Quarterly. 739(3): 217-228.

[25] Gooding, P., Anderson, J. and McVilly, K., Disability and social inclusion 'Down Under': A systematic literature review

The scope of social inclusion is limited, and may focus on a minimal level of participation, which may still mean the person exists at the fringes without necessarily living a "good life."[26]

Social inclusion tends to be a top-down policy or practice, implying that someone else, typically a state-based service, is doing the including, rather than the person making active demands and contributions on an equal basis with other citizens. [27]

Social inclusion in disability policy and practice do not, overall, aim to radically transform communities or to engage with the broader systemic concerns that lead to and perpetuate exclusion, mental health issues and disability.

More promising approaches for services to do effective inclusion work with a focus on longer-term and larger scale transformation include:

- Helping people connect to local groups, employment opportunities, or to maintain and/ or discover relationships
- Offering resources and advocating to community groups, services, workplaces, and other settings to assist them to become more open and accessible to people with disabilities and mental health issues
- Advocacy for change on exclusionary or discriminatory practices; and
- Offering resources and support to individuals and to families to increase their self-advocacy and capacity to develop social connections.

A focus on active citizenship is at the heart of the approach. Being connected and having a sense of belonging is fundamental to everyone's experience of a full and rewarding life. Communities also benefit enormously from the diversity and richness of ideas, experiences and knowledge that people with a disability bring to cultural, social and civic life.

Achieving this means directing our efforts to community transformation – by engaging community members as allies; creating welcoming spaces in community; and building and supporting a grassroots advocacy movement in which the people who are most affected by disability can join their voices, step into leadership roles and have real influence at local, state and national level.

Government funded employment support

Too many people affected by mental health issues still experience high levels of unemployment, poverty, isolation and exclusion. Wellways has a longstanding commitment to improving employment outcomes for people who experience mental health issues. Wellways support any opportunity to develop a whole of community and service system response to the needs of job seekers and workers who experience mental health issues. Achieving better employment outcomes will involve a commitment from government, community, businesses, individuals, families, providers, disability and health services to work in partnership to address longstanding barriers to meaningful and sustainable social and economic participation.

Finding and Keeping a Job

Employment outcomes remain poor, particularly for people with a mental health issues who make up the largest proportion of unemployed people with a disability. Traditional approaches to employment service provision which have not been successful to date continue to be funded under the new system. For example, maintaining and increasing wage subsidies, retaining a strong link with social

[26] Gooding, P., Anderson, J. and McVilly, K., Disability and social inclusion 'Down Under': A systematic literature review
[27] Daly, M. and Silver, H., (2008) Social exclusion and social capital: A comparison and critique, Theory and Society 37(6): 537–66.

security compliance measures and the continuation of programs which focus on individual 'job-readiness'.

Most of these approaches are not evidence based and have not led to sustainable employment outcomes to date. In comparison, evidence-based approaches to employment support such as the Individual Placement and Support Model and Peer Support have not been widely implemented and continue to be under-funded. There remains little to no investment in engaging the wider community, for example targeted programs which focus on creating more inclusive work environments and opportunities or appropriate supports for employers and employees at risk of job loss due to mental ill health. There is also a lack of targeted employment programs available to support families and carers affected by mental health issues.

Although government run programs (predominately funded by the Commonwealth) have targeted a wide population group, there are cohorts that have traditionally not been served well. These include:

- People with severe mental health issues inappropriately labelled as not 'job ready' or incapable of work. The service system does not encourage this cohort of people to take steps towards employment without fear of negative impacts to existing benefits. Stigma remains a significant barrier for this cohort with mental health awareness campaigns focussed predominantly on depression and anxiety.
- Community groups and employers – financial incentives are available but targeted evidence-based programs are needed which support employers to create and foster inclusive work environments and opportunities that are sustainable long term and address underlying barriers
- Current employees at risk of job loss due to emerging mental health concerns.
- Families and carers.

Recommendation:

Employers and the Workplace

Being employed is generally good for people's mental health and wellbeing. The workplace provides an important opportunity for people to build resilience, develop social networks and develop their own mental capital. Employers in all sectors, including the public sector, can play an important role in supporting the health and wellbeing of their staff by providing healthy workplaces which support their employees' mental health and wellbeing.

Employment can also be an important part of many people's recovery from mental health issues. People with mental health issues can and do work – and supporting them to do so can save employers significant costs relating to staff turnover, under-performance and untapped potential. There is a considerable amount of guidance available on what employers can do to help people with mental health issues to stay in, return to and perform well at work. Often these are simple, low-cost and common-sense interventions.

Achieving better employment outcomes will involve a commitment from the Victorian Government, the community, businesses, individuals, families, providers, disability and health services to work in partnership to address longstanding barriers to meaningful and sustainable social and economic participation. What is required is a covenant between the Victorian Government and its non-government partners to look at ways of improving the health and wellbeing of the working-age population to enable people to remain in employment and return to work after a period of poor mental health.

Alternative approaches for better support

An 'all of community approach' is required to improve employment opportunities and outcomes for people who experience mental health issues.[28] This means equal weight should be placed on providing education and support to employers and community groups as there is placed on programs which support individual job seekers.

Research shows that the most effective means to reduce barriers to inclusion, such as stigma, is through direct contact with someone with a lived experience of disability or mental health issues. Any initiatives which aim to increase employers understanding of the benefits of employing someone with a disability or mental health issue should include and be led by people with lived experience of their own.

Research also shows that the Individual Placement and Support (IPS) model continues to be the most effective model to support people who experience mental health issues into competitive employment. This model has been evaluated in 23 randomised controlled trials across North America, Europe, Asia and Australia.[29] The IPS model can be further strengthened to achieve long term outcomes through the inclusion of best practice approaches such as peer support and engagement with families.[30]

An effective all of community response requires a skilled and motivated workforce to implement new measures and engage with the community. This workforce must include lived experience or peer expertise. Research shows that peer support has positive impacts on a person's sense of self, health and wellbeing, confidence and their engagement in community. It is this type of reform which we believe will result in significant improvements in employment outcomes.

Coordination and integration

Overall, the mental health system has an illness framework, which targets a particular 'illness' event in a person's life and is led by Victorian Local Health Districts (LHDs) and the Commonwealth's Primary Health Networks (PHNs). The system does not focus on the person living in the community, despite most people who access the formal system only having contact is between 16 days and 12 weeks. The primary health system has a session, office-based focus, often unsuited to those with mental health issues. At the extreme end when a person is very unwell, they may not be able to get out of bed, let alone keep a doctor's appointment.

After an illness 'event', for the rest of the time people are left to their own devices and if homeless remain homeless, if unemployed remain so. Some regional plans allow for local connections; however, they do not provide for broader social system solutions which are seen through a health intervention lens, rather than through personal and community capacity building.

As well, each state and territory holds its own political imperatives which in broad terms commit to the national mental health plan, however, this is part of the problem. Each jurisdiction finds different solutions and calls these solutions by different names, making benchmarking very difficult. Health organisations have a very narrow focus on fixing a health event and rarely have an interest in how the individual deals with isolation experienced in their community.

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[28] Salzer, M.S. and Baron, R.C., (2016) Well Together: a blueprint for community inclusion: fundamental concepts, theoretical frameworks and evidence, Melbourne, Australia.
[29] Bond, G. R., Becker, D. R., Drake, R. E. and Vogler, K. M., (1997) A fidelity scale for the Individual Placement and Support model of supported employment, Rehabilitation Counseling Bulletin, 40(4), 265-284.
[30] Murphy, A. A., Mullen, M. G. and Spagnolo, A. B., (2005) Enhancing Individual Placement and Support: Promoting Job Tenure by Integrating Natural Supports and Supported Education, American Journal of Psychiatric Rehabilitation, 8(1), 37-61.

Additionally, the Commonwealth funds PHNs, each of which compete with one another for delivery and while there are overall rules it is difficult to see overall patterns of coordination. These PHNs tender their work, often these tenders are short term which does not encourage system building. Further the formal focus of health agencies to strategically support civil society development plays a second fiddle to the direct health activities.

These barriers to more effective integration, also include the culture of each institution, and the language used to describe the phenomenon. For example, homelessness is a major problem for each state and territory, within government departments there are arguments about which part of government departments will take on ownership, mental health claiming it's a housing issue and housing making opposite claims. Within health the problems also exist, with the LHDs allocating mental health money to high priority health issues.

The Australian Institute of Health & Welfare reports health outcomes but does not include meaningful institutional integration data with the non-health institutions. While employment reports on mental health outcomes, with 72 per cent of the cohort unemployed, it is not required to report nor intervene to improve. The newest entrant into the health and disability world is a classic example of further fragmenting integration, making it impossible to provide a continuum of care.

The frameworks for developing policy about mentally healthy communities needs to take an approach that is broader than illness i.e. non-mental health departments having a contribution to make to the mental health of the nation. Certainly, there will be times when a person requires a health intervention, but may concurrently need support to attain a home, get a job, deal with social isolation.

These supports cannot be acquired through one institution. At times a person needs non-office-based supports to be in and of the community to assist access, and connection. It requires governments to rethink the tasking of their departments.

Mental health treatments and support have been developed as an activity-based model, addressing this issue and that, in isolation from each. This approach has delivered a chopped-up approach to complex issues that need multiple interventions from multiple systems and for people who experience high distress a system that excludes them and has ineffective community access points.

Mental health issues often result in a person having multiple domains of their lives that are under stress, without access to effective community interventions that are non-stigmatising and support them to improve their situation.

Recommendation:

Multi-disciplined community-based support teams

Multi-disciplinary community-based support teams should be established across Victoria to support people with mental health issues to remain and thrive in the community.

The teams should comprise experts in housing, education, employment, family and carers, health service systems and community resources and should be peer-led.

The teams should use evidence-based practices such as Individual Placement & Support model for employment and Housing First principles for housing.

Funding arrangements

Existing arrangements for commissioning and funding mental health services, especially community managed non-clinical mental health services delivered by NGOs, is wasteful.

Competitive Tendering Issues

Each of our contracts have been awarded through a competitive tendering process.

These processes vary widely, with differing requirements from commissioning agencies, e.g.: A recent state-wide tender was to deliver community support services to people in the community who could not access NDIS. This included people with psychosocial disability. The tender was to distribute $110 million. There were four criteria to be addressed and the word limit for each criterion was one A4 page. The sub-points required to be addressed for each criterion themselves ran from a quarter to half a page.

In contrast, a similar tender, totalling $219,635 per annum for three years, had no word limit and seven major criteria with 22 sub-points. Wellways' submission ran to 58 pages.

Compliance and Reporting

There exists huge duplication because each contract has its own reporting and acquittals. As with the competitive tendering process, the level of reporting is not commensurate with the value of the contract.

Government departments have always been more demanding in terms of reporting and acquittals. Victorian LHDs and the Commonwealth's PHNs have continued in this vein, even though the service contracts are often for relatively small amounts of money.

Because of the nature of funding to LHDs and PHNs, many of the contracts tendered are for one year only, with the possibility of extension contingent on further funding. This de-stabilises the workforce and makes it more difficult to recruit and retain qualified and skilled staff.

None of these processes is conducive to quality service delivery achieving outcomes for clients, but rather diverts resources into compliance, reporting and tender writing.

Recommendation:

Streamlined compliance for reporting

The government should streamline compliance requirements for reporting and accreditation to reduce administrative burden and heavy resource requirements that take money and time away from service delivery

The government should work across government at federal and state levels to establish common requirements for tendering and commissioning to streamline processes, create consistent quality and promote greater equity for applicants

The government should explore less expensive and less wasteful methods of procurement than competitive tendering such as direct commissioning or social impact bonds funding based on outcome data