Response to Productivity Commission Inquiry into the social and economic benefits of improving mental health

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ADACAS Submission - Productivity Commission Inquiry - Social and Economic Benefits of Improving Mental Health (April 2019)

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1. About ADACAS

The ACT Disability Aged and Carer Advocacy Service (ADACAS) has been providing advocacy for and with people with disability, older people, people with mental health issues and carers for 28 years. We are based in Canberra, and work with clients in both the ACT and set zones in the Shoalhaven and Eurobodalla areas of NSW. As an advocacy service, ADACAS is frequently working with people with mental ill health who are "falling through the cracks" in current service systems. We additionally offer support coordination to a small number of NDIS participants, and have a Projects/research team, who are currently conducting action research looking at Supported Decision Making in Healthcare.

ADACAS is very pleased to have the opportunity to present its perspective on this important topic, and the submission begins with a general expression statement in response to the Productivity Commission Issues Paper, followed by a more detailed examination of the questions the Commission has asked in the various sections of the report[1]. Throughout this submission we seek to highlight the issues that our clients have raised with us, and will use case studies to demonstrate circumstances that have occurred. We value the opportunity to make comment on what can be improved.

2. General statement in response to the Productivity Commission Issues Paper

As an organisation that works with a very diverse clientele, ADACAS is aware of different ways that individuals lead valued (ordinary) lives. Given this, we observe the need for inclusive conceptualisations of mental health and understandings of what a valued (ordinary) life might look like: we strongly contend that work status should not be elevated above other pathways.

Australian society needs to take an integrated approach in designing structures and systems which are better able to respond and provide critically needed supports to those who are most severely affected by mental ill health, as well as looking to intervene early for future.

There is immense value in challenging inequality and poverty directly: in ending homelessness and housing insecurity, of ensuring the availability of best practice medical treatments, and ensuring support to enable equitable access to opportunities, to services, and to justice.

We ask of the Productivity Commission to examine both the systems and structures which can improve mental ill health, in addition to those that are currently having adverse impacts, keeping people mired in poverty, or otherwise contributing to trauma or cycles of disadvantage.

We applaud efforts to recognise and facilitate the mental health & wellbeing of our community to enable active participation in productive activity for all.

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[1] Productivity Commission 2019, *The Social and Economic Benefits of Improving Mental Health* (Productivity Commission Issues Paper: January 2019)

3. ADACAS Recommendations

Recommendation 1: ADACAS recommends that both Autism Spectrum Disorders and Substance Use Disorders be included within the scope of the Productivity Commission Inquiry.

Recommendation 2: ADACAS recommends that as part of this Inquiry, that Productivity Commission analyse policies and approaches which have or have the potential to have adverse impacts on mental health as well as policies and approaches that are or have the potential to improve mental health.

Recommendation 3: ADACAS recommends that in developing a model of care, that the Productivity Commission prioritise initiatives that encourage structures, systems and services to respond better and more equitably to presenting need.

Recommendation 4: ADACAS recommends that best practice clinical and recovery support be extended such that it is available to people with PTSD, people with psychosis, people with personality disorder diagnoses, people who have experienced trauma and/or abuse, people with eating disorders, autistic people, that plans are formulated in collaboration with the individual, and that treatment is available at a level which meets the clinical requirements for best practice treatment and support.

Recommendation 5: ADACAS recommends an increase in the availability of non-clinical and early intervention support for mental health in the community.

Recommendation 6: ADACAS recommends that hospitals be funded to support people with mental ill health at a level commensurate with the need for inpatient support.

Recommendation 7: ADACAS recommends that additional carer support and respite be made available, commensurate with the level of community need.

Recommendation 8: ADACAS recommends that all levels of government treat homelessness as an emergency and urgently address it, with investment in specialist outreach and support services and in housing stock and in supportive housing solutions to match the level of need.

Recommendation 9: ADACAS recommends that the rate of Centrelink payments such as Newstart, Youth Allowance and related pensions are increased to take account of the current costs of living.

Recommendation 10: ADACAS recommends that the Australian government increase funding person-centred coordination and recovery support for people with complex needs, commensurate with the level of need in the community.

Recommendation 11: ADACAS recommends an increase in the funding for individual advocacy support for people with mental illness and people with complex needs.

Recommendation 12: ADACAS recommends early intervention, and to enable more equitable outcomes from the justice system for people with mental ill health.

Recommendation 13: ADACAS recommends alternative processes to adversarial court processes when at all possible (i.e. mediation, family group conferencing, and a restorative justice approach), and that people who are vulnerable have additional independent support made available when needed to enable equitable participation.

Recommendation 14: ADACAS recommends ongoing monitoring of and continued efforts to improve education experiences for (and counter discrimination and stigma against) students with mental ill health and disability.

Recommendation 15: ADACAS recommends that there be additional initiatives and incentives to support mental health in workplaces and to recruit, support and retain people with mental ill health, people with disability and carers in the workplace.

Recommendation 16: ADACAS recommends that resourcing levels for the sector be at a level where services can both respond to need and collaborate more easily.

4. Responses on Specific Topics

a. Scope of Inquiry

The broad scope of this Productivity Commission inquiry is welcome, as are the decisions to consider the array of social and economic determinants of health and to take a whole of government / whole of community approach in analysis of the issues. Given the intent to give the greatest consideration to where there are the largest potential improvements in population mental health we suggest that supports for the following especially disadvantaged groups merit closer consideration:

- People with severe mental illness / psychosocial disability
- People with chronic illness (or chronic pain) and mental ill health
- People with co-occurring disability* and mental ill health (*both those eligible for and those ineligible for an independent support package via the NDIS). Carers

The World Health Organisation identifies mental and substance use disorders as the leading cause of disability worldwide, suggesting that "about 23% of all years lost because of disability is caused by mental and substance use disorders"[2]

At the present time, people with mental illness (and people with disability) are over-represented in chronic homelessness[3], within prison populations[4] and as victims of crime[5][6]. Whilst some of these experiences themselves may also be contributing to mental ill health, in ADACAS' is vital that the social and economic determinants of health for these groups be closely considered and improved.

With regards to specific disorders that are included and considered within this Inquiry, we make the following comments:

- <u>Autism Spectrum Disorders:</u>

    Whilst we acknowledge that there are many members of the autism community who identify autism as neurodivergence and challenges to classifications of

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[2] World Health Organisation, *10 facts on Mental Health*, World Health Organisation, viewed on 15 April 2019, https://www.who.int/features/factfiles/mental_health/mental_health_facts/en/index1.html

[3] Brackertz, N, Wilkinson A, & Davidson, J (2018), *Housing, homelessness and mental health: towards systems change,* a report from the Australian Housing and Urban Research Institute (AHURI) for the Australian Government National Mental Health Commission, page 11, viewed on 11 April 2019, https://www.ahuri.edu.au/research/research-papers/housing-homelessness-and-mental-health-towards-systems-change

[4] Australian Institute of Health and Welfare 2015. The health of Australia's prisoners 2015. Canberra: AIHW, viewed on 11 April 2019: https://www.aihw.gov.au/reports/prisoners/health-of-australias-prisoners-2015/contents/mental-health-of-prison-entrants

[5] Hiroeh U, Appleby L., Mortensen PB, Dunn G, (2001), Death by Homicide, Suicide, and Other Unnatural Causes in People with Mental Illness: a Population-Based Study, *The Lancet,* Volume 358(9299), pp.2110-2112.

[6] Hiday VA, Swatz MS, Swanson JW, Borum R and Wagner HR (1999), Criminal Victimisation of Persons with Severe Mental Illness, *Psychiatric Services,* Volume 50(1), pp.62-68.

autism as mental illness[7], we believe that autism spectrum disorders should nonetheless be included in the scope of this inquiry. In many circumstances, autistic people* and/or their family and friends advise us that NDIS or other supports are needed. Whilst entry to the NDIS was to have been predicated on impact on functional capacity, our experience is that NDIS entry for autistic people appears to have become more reliant on diagnostic levels: with an autistic person generally seeming to need a diagnosis with severity level of Autism Level 2 or 3 (as opposed to Level 1) (in reference to the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5))[8] to be able to gain NDIS access (Level 2 and 3 are on the NDIS List A of conditions which are likely to meet the entry criteria[9]).

Research demonstrates that autism and a variety of mental illnesses frequently co-occur.[10] People with both autism and mental ill health diagnoses report that they frequently seek to access support from multiple sectors without success and that their support needs are not being met"[11], similar outcomes are reported not only in Australia, but also internationally[12].

At the present time, it is our experience that there is a significant gap not just in terms of the support available to autistic people, especially those diagnosed with Autism Level 1, but also in terms of support for people with mental ill health who also have an autism diagnosis. A UK study entitled '*People like me don't get support': Autistic adults' experiences of support and treatment for mental health difficulties, self-injury and suicidality*"[13], reflects also the themes we hear from our clients. Given this we strongly support a decision to include autism spectrum diagnoses as part of the Productivity Commission Inquiry.

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[7] Beck, T, (2018) Tracing disorder across theories of autism, empathy, and mental health care, *Disability & Society*, 33:8, 1303-1326.

[8] American Psychiatric Association (2013), Diagnostic criteria for autism from *The Diagnostic and Statistical Manual of Mental Disorders (5th ed, DSM–5)*, accessed via: https://www.autismspeaks.org/dsm-5-criteria, viewed on 11 April 2019.

[9] National Disability Insurance Agency, (2019), *List A- Conditions which are likely to meet the disability requirements in section 24 of the NDIS ACT, NDIS Operational Guidelines*: Access to the NDIS, viewed on 16 April 2019, https://www.ndis.gov.au/about-us/operational-guidelines/access-ndis-operational-guideline/list-conditions-which-are-likely-meet-disability-requirements-section-24-ndis-act#14.

[10] Cage E, Di Monaco J, Newell V, (2018), Experiences of Autism Acceptance and Mental Health in Autistic Adults, *Journal of Autism and Developmental Disorders*, 48(2): 473–484, Published online 25 October 2017, https://www.racgp.org.au/afp/2015/november/management-of-mental-ill-health-in-people-with-autism-spectrum-disorder/

[11] Autism Advisory Board on Autism Spectrum Disorders (2012), *The interface between autism spectrum disorders and mental health: the ways forward*, Discussion Paper, NSW, Australia, viewed on 12 April 2019, http://www.autismadvisoryboard.org.au/uploads/file/pdfs/The%20Interface%20between%20ASD%20and%20Mental%20Health%20AAB.pdf

[12] World Health Organisation (2018), *Autism spectrum disorders: Key facts*, viewed on 5 April 2019 https://www.who.int/news-room/fact-sheets/detail/autism-spectrum-disorders

[13] Camm-Crosbie, L., Bradley, L., Shaw, R., Baron-Cohen, S., & Cassidy, S. (2018). 'People like me don't get support': Autistic adults' experiences of support and treatment for mental health difficulties, self-injury and suicidality. *Autism*. https://doi.org/10.1177/1362361318816053

(*Given the prevalence of identity-first language amongst autistic people, in this paper we have sought to respect that by generally use the phrase "autistic person" instead of person with autism. In doing so we acknowledge that there is continued debate as to whether person-first or identity-first language choices are more acceptable and acknowledge varying preferences).

- <u>Substance use disorders:</u>

  In our view, substance use disorders should be included within the scope of the Productivity Commission inquiry, as there is considerable research demonstrating strong associations between substance use disorders (including illicit drug use) and mental ill health. [14] [15]

<u>Recommendation 1</u>: ADACAS recommends that both Autism Spectrum Disorders and Substance Use Disorders be included within the scope of the Productivity Commission Inquiry.

[14] Marel C, Mills KL, Kingston R, Gournay K, Deady M, Kay-Lambkin F, Baker A, Teesson M (2016). *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition).* Sydney, Australia: Centre of Research Excellence in Mental Health and Substance Use, National Drug and Alcohol Research Centre, University of New South Wales.

[15] Australian Institute of Health and Welfare (AIHW) (2018), *Alcohol, tobacco & other drugs in Australia*, Canberra, viewed on 13 April 2019, https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/people-with-mental-health-conditions

b. Assessment Approach

When considering the assessment approach, it seems critical to acknowledge the impacts of the social determinants of all health, including those processes and systems which have significant **<u>adverse</u>** consequences.

In particular we highlight:

- Income scarcity
  - Government pensions and benefits are set at such low levels that people become mired in poverty (with all the added inequality and disadvantage, and negative impacts for health that this can bring)[16][17].
  - Centrelink processes: We highlight the profoundly negative impacts of robo-debt program[18] (which needs to stop), also policy decisions which mean that access to Centrelink social workers is usually only via phone, which changes the support that it is possible for them to offer people in crisis or who are vulnerable. We highlight negative impacts of mutual obligation requirements of Newstart (and similar Centrelink) allowances where people are penalised if they are unable to fulfil job activity requirements, and where the structure does not always adequately allow for support of people who are vulnerable. Variations to existing structures are less efficient a response than a scheme designed with equitable access including support available when and where it is needed.
- Homelessness
  - Despite being a first world country, inadequate housing and support services mean that some of the most disadvantaged Australians remain without safe and secure accommodation and supports via which their needs are met.
- Violence and trauma:
  - There continues to be insufficient funding to adequately support initiatives to (when possible) prevent violence and trauma from occurring, and a lack of a robust policy framework to address these topics.
  - There are many other important social topics where preventative work could make a marked difference both to respecting individual human rights as well as improving mental health, for example additional investment in early intervention supports to assist people with emerging mental ill health, initiatives to enable people living in residential aged care to go out more easily and frequently and further engage and

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[16]Australian Council of Social Services and University of New South Wales Sydney (2018), *Poverty in Australia 2018*, pages 5 and 25, viewed on 12 April 2019 https://www.acoss.org.au/wp-content/uploads/2018/10/ACOSS_Poverty-in-Australia-Report_Web-Final.pdf

[17]PricewaterhouseCoopers (PWC) (2011), *Disability expectations: Investing in a better life, a stronger Australia,* viewed on 12 April 2019 https://www.pwc.com.au/industry/government/assets/disability-in-australia.pdf

[18] Carney T, (2019), 'Robo-debt illegality: The seven veils of failed guarantees of the rule of law?' *Alternative Law Journal*, 44(1), 4–10, https://doi.org/10.1177/1037969X18815913

remain connected with family, friends and community outside the aged care facility, added support to respond to and prevent crime and trauma, additional support for people living with mental ill health who are involved with or at risk of entering the justice systems, etc.

Recommendation 2: ADACAS recommends that as part of this Inquiry, that Productivity Commission analyse policies and approaches which have or have the potential to have adverse impacts on mental health as well as policies and approaches that are or have the potential to improve mental health.

c. Structural Weaknesses in Health Care

We endorse the issues highlighted in the list on page 12 of the issues paper. Things to incorporate within the current reform agenda:

- Model of care

Overall, whilst recognising the constraints that exist in all funded service delivery with no direct cost to client, the most efficacious service responds to presenting need rather than waiting for the need to fit the available service. The acknowledged value of early intervention provides evidence that if a support response is available when the need is presented there is less likely to be increased need and complexity of need in the future. We suggest that this drives the consideration of a model of care that is then, equitable to access and responsive to need.   Any such model of care, needs to encompass clinical and non-clinical recovery-focused mental health specific supports, in addition to the non-health-specific supports (housing / justice / education / income payments etc.). Funding also needs to be at sufficient levels to allow for services to have time to collaborate and work together with each individual person to achieve better outcomes.

- Short term funding cycles and grants

When funding and grants are offered only or largely via short term funding cycles and grants, this can exacerbate the issues, in that services are unable to be flexible in response to specific needs as they present and act in ways to prevent and reduce adverse consequences.   It also inhibits the ability of services to forecast/plan for the longer term.

Recommendation 3: ADACAS recommends that in developing a model of care, that the Productivity Commission prioritise initiatives that encourage structures, systems and services to respond better and more equitably to presenting need.

d. *Specific Health Concerns: Clinical services:*

There are improvements needed with existing clinical services that could result in better outcomes for people who experience mental ill health.

We have identified the following concerns:

- <u>Significant Service Gaps in availability of available clinical treatment and recovery support for people with complex needs:</u>

In terms of the availability of specific best practice clinical treatments - there is a recognised paucity of publicly available services in the ACT (and elsewhere) offering specific best practice clinical treatment and ongoing recovery support for people with certain types of conditions, especially conditions such as:

  - PTSD (and for other people who have experienced trauma or abuse)
  - Psychosis
  - Personality Disorders
  - Eating Disorders
  - Autism Spectrum Disorders and co-occurring mental ill-health
  - Cognitive impairment/complex mental ill health (where diagnosis is unclear and/or situations where there is a lack of support available to the client to assist with the understanding of the diagnosis).

- <u>The availability of Medicare-subsidised private psychologist therapy sessions are limited, for example:</u>
  - Better Access to Mental Health Care (BAMHC) offers a maximum of 10 sessions with a psychologist OR
  - Next Step (High Intensity Program, which replaces ATAPS in Canberra), maximum 18 sessions AND/OR
  - Chronic Disease Management Program, maximum 5 sessions

  This is often insufficient to support people who need more intensive treatment or support such that they can achieve and maintain better health and circumstances in the longer term.

- <u>Additionally, sometimes there are extra constraints/barriers to access:</u>
  - Co-payments can be prohibitive barriers to access for people with low incomes accessing private psychologists (APS psychologists fees are typically around $200-$250 per hour, with only a portion of this covered via Medicare).
  - Clients accessing private psychologists are also frequently requested to have the funds available to pay for psychology upfront and claim later.
  - With the Next Step (High Intensity) program, clients can only access psychologists from the service delivering the specific program (CatholicCare) (as opposed to via a psychologist with whom they may have had an existing relationship, or whom they have sought out due to a specific area of expertise).

  It is important that there also be alternative responses and options available for when a person needs support and the relationship with the only existing service provider (e.g. ACT Mental Health) has broken down.

Inadequate availability and funding for hospital and post hospital mental health and housing care: One of the Official Visitors (Mental Health) in the ACT has advised ADACAS that there have been consistently more people seeking inpatient mental health care at the Canberra Hospital Adult Mental Health Unit (AMHU) than the number of designated mental health beds. The Official Visitor has explained that especially in late 2018/ early 2019, there were times where as many as 16 people would be waiting in the emergency department for a bed in AMHU, and that during this period, other wards of the main hospital were regularly being co-opted to accommodate people with mental ill health. Media reports[19] evidence this very high level of demand. The Official Visitor advised ADACAS: "Feedback from AMHU staff during this period included concerns that many consumers were being exited from the unit much earlier than was appropriate due to pressures on beds".

The point of discharge from hospital or mental health institutions can be a significant point of risk for discharge into homelessness.[20]

A person had been receiving treatment as an inpatient at the Adult Mental Health Unit. Efforts were being made by hospital staff to connect the person to community supports (including supported housing), however the person was discharged before these could be finalised.
The person was advised to go and stay at the nearest campground (despite the person not having any camping equipment or connections there) or to go to a (full and unsuitable for the person's needs) refuge.
Due to nights without suitable accommodation or support, the person subsequently become more unwell and will likely return to hospital again soon.

Recommendation 4: ADACAS recommends that best practice clinical and recovery support be extended such that it is available to people with PTSD, people with psychosis, people with personality disorder diagnoses, people who have experienced trauma and/or abuse, people with eating disorders, autistic people, that plans are formulated in collaboration with the individual, and that treatment is available at a level which meets the clinical requirements for best practice treatment and support.

Recommendation 5: ADACAS recommends an increase in the availability of non-clinical and early intervention support for mental health in the community.

Recommendation 6: ADACAS recommends that hospitals be funded to support people with mental ill health at a level commensurate with the need for inpatient support.

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[19] White, D (2019), "Canberra Hospital's adult mental health unit bursting at the seams", The Canberra Times, published on 7 January 2019, viewed online on 29 March 2019, https://www.canberratimes.com.au/national/act/canberra-hospital-s-adult-mental-health-unit-bursting-at-the-seams-20190106-p50puc.html

[20] Brackertz, N, Wilkinson A, & Davidson, J (2018), *Housing, homelessness and mental health: towards systems change,* a report from the Australian Housing and Urban Research Institute (AHURI) for the Australian Government National Mental Health Commission

e. Health Workforce and Informal Carers

Many of the people with whom ADACAS works, people who experience mental ill health, **do not have an established support network sufficient to meet their needs,** whether family, friends or others willing to provide informal care and support.

Any system that relies on the assumption that informal care is available to everyone, further marginalises and disadvantages an already additionally vulnerable group, and does not respect that the impacts of the disability or mental illness itself may be contributing to the lack of support networks.   Even for those who do have informal family carers or friends willing to offer support - an over-reliance on informal carer support can place incredible stress on relationships, to the extent that they break down. It can mean an increase in stress, burnout and mental ill health amongst carers, and also the people for whom they are caring, and increase social isolation and the vulnerability of multiple people.

> *"I just can't do it any more. It is too much. What do they expect of me, to just keep going until I break?"*
>
> A carer in conversation with ADACAS

> *"My health issues (health and mental ill health) over the last few years have placed enormous strain on my relationships. My partner is being pressured at work not to undertake her caring role, and also left me for a period last year due to the stress. I've had family and friends literally disappear, some with stabbing hurtful remarks about my ill health issues ruining my partner's life on the way. I've lost my hobbies, my control over what I get to be part of, and my independence to do most things (when historically I was so independent)"*
>
> ADACAS client

ADACAS supports the need for additional carer support and respite. In line with this we endorse the comments made by Carers Australia[21] in their submission to this Productivity Commission Inquiry relevant to the needs of carers.

Additionally, there needs to be further training and ongoing mentoring and incentives for workplaces to recognise, understand and make reasonable adjustments to allow carers to be able to perform their caring roles.

Recommendation 7: ADACAS recommends that additional carer support and respite be made available, commensurate with the level of community need.

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[21] Carers Australia (2019), Submission to the Productivity Commission Issues Paper on the Social and Economic Benefits of Improving Mental Health, https://www.pc.gov.au/__data/assets/pdf_file/0004/240970/sub372-mental-health.pdf

f. Housing and Homelessness

"Homelessness is one of the most potent examples of disadvantage in the community, and one of the most important markers of social exclusion (Department of Human Services, 2002)."[22] On 2016 census night there were 1596 people homeless in Canberra[23]. It is estimated that many of the people who are homeless experience mental illness or disability[24].

In ADACAS' view homelessness needs to be treated as an **emergency** and urgently addressed, with significant investment in specialist outreach and support services, and investment in safe and appropriate housing stock and in supportive housing solutions[25] at a level that matches the need[26]. We consider that there is both a moral and financial imperative for all levels of government to act fast and end homelessness.

Whilst recognising the importance and role of specialist services, ADACAS also supports building capacity within all housing services to understand and better respond to and assist people who are homeless and experiencing mental ill health (or who have experienced trauma and need a trauma informed approach), rather than relying solely on specialist support services.

When suitable housing options are unavailable, this can mean very extended stays in tertiary health care facilities and, as earlier mentioned, the adverse mental health and health impacts when people are discharged into homelessness from hospital or other institutions[27].

We are aware also of people who have needed to prioritise their mental health by leaving housing in which they felt unsafe (perhaps due to neighbours, or violence in the home, or general safety issues) to live temporarily with friends, in refuges or on the streets: in doing so, often increasing their vulnerability.

<u>Recommendation 8</u>:   ADACAS recommends that all levels of government treat homelessness as an emergency and urgently act (in line with best practice research) to resolve and end this issue.

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[22] Australian Bureau of Statistics (2018), *Census of Population and Housing: Estimating homelessness, 2016* viewed on 15 April 2019, https://www.abs.gov.au/ausstats/abs@.nsf/mf/2049.0

[23] ACT Council of Social Services (2018), *ACT homelessness data- A closer look¸* media release 16 March 2018, https://www.actcoss.org.au/news-events/actcoss-news/act-homelessness-data-closer-look

[24] Flatau P, Tyson K, Callis Z, Seivwright A, Box E, Rouhani L, Lester N, Firth D, Ng, S-W (2018), *The State of Homelessness in Australia's Cities: A Health and Social Cost Too High*, Centre for Social Impact The University of Western Australia, Perth, Western Australia, www.csi.edu.au/research/project/the-state-of-homelessness

[25] Parsell, C., Moutou, O., Lucio, E. and Parkinson, S. (2015) Supportive housing to address homelessness, AHURI Final Report No.240. Melbourne: Australian Housing and Urban Research Institute, accessed on 15 April 2019, available from: http://www.ahuri.edu.au/publications/projects/21024

[26] ACT Council of Social Services (2018), *ACT homelessness data- A closer look¸* media release 16 March 2018, https://www.actcoss.org.au/news-events/actcoss-news/act-homelessness-data-closer-look

[27] Brackertz, N, Wilkinson A, & Davidson, J (2018), *Housing, homelessness and mental health: towards systems change,* a report from the Australian Housing and Urban Research Institute (AHURI) for the Australian Government National Mental Health Commission, page 11, viewed on 11 April 2019, https://www.ahuri.edu.au/research/research-papers/housing-homelessness-and-mental-health-towards-systems-change

g. Income Support

The impact of poverty/financial distress

Poverty has evident and profoundly adverse impacts on mental health and wellbeing, and aspects of the current social security arrangements are exacerbating marginalisation. ACT Council of Social Services observe: "Income support payments such as Newstart and Youth Allowance have fallen behind the cost of living, with essential goods and services becoming less and less affordable for income support recipients. Newstart has not increased in real terms in 24 years and now more than half of the people on Newstart live below the poverty line".

> *I applied for the DSP but they rejected my application. I'm appealing, but what am I meant to do in the meantime? I am receiving Newstart, but it is not enough to live on. Newstart is not even enough to get by. I'm struggling to pay my rent, I have to choose between food, medicine and paying my bills. My local Centrelink office keeps advising me to apply for work, but I can't work anymore, I'm not well enough. I hate this. Don't they know that if I could work, I would? I've had to go without heating this winter, as the bills were too high. Living like this, without enough money or support: it is unspeakably awful: it makes you feel like no-one cares, like you don't matter. I want to see my psychologist but I can't even afford to do that. I'm in a dark place.*
>
> ADACAS Client

Many of the current structures (Centrelink approaches and policies) are having an adverse impact on the mental health of our clients, and are also placing additional obstacles in the way of their economic participation. Given this, we endorse the **raise the rate initiative**[28] which supports an increase in the rate of payment for people receiving NewStart, Youth Allowance and related payments.

Income security compliance issues can deprive people who are vulnerable of the time and money to be involved, and/or to build more extended social networks alternatively we contend that alleviating hardship can promote increased community mental health and wellbeing[29].

Recommendation 9: ADACAS recommends that the rate of Centrelink payments such as Newstart, Youth Allowance and related pensions are increased to take account of the current costs of living.

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[28] ACT Council of Social Services (ACTCOSS) (2018), *Poverty and inequality in the ACT*, May 2018 Factsheet, Canberra, viewed on 5 April 2019, https://www.actcoss.org.au/sites/default/files/public/publications/2018-factsheet-poverty-and-inequality-in-the-act.pdf

[29] Kiely KM, Leach LS, Olesen SC, Butterworth P (2015), 'How financial hardship is associated with the onset of mental health problems over time", *Social Psychiatry and Psychiatric Epidemiology*, 2015 Jun, 50(6):909-18, doi: 10.1007/s00127-015-1027-0, Epub 2015 Feb 17, https://www.ncbi.nlm.nih.gov/pubmed/25683473#

h. Social Services

- <u>Significant Service Gaps in availability of ongoing coordination assistance and person-centred recovery support for people with complex needs:</u>
  The service system is complex, and it is not infrequent that there are people who find themselves in complex situations where they are needing to liaise with multiple service systems simultaneously. In addition they may often be penalised for "failing to engage" to a standard set by each system which can encourage people to prioritise based on the least desirable penalty or cease engagement with all as it is overwhelming.

> *"I attend appointments with services (and lawyers), usually multiple appointments, every day all over town. It takes all my energy to keep track of and attend all the appointments. In addition to that, I have things occurring in the family court also in other courts– there is so much paperwork in relation to all the legal stuff).*
>
> *My disability makes it hard to read. The medication for my mental illness makes it hard to concentrate. I have to coordinate it all.*
>
> *I just want one person to liaise with, to help me coordinate/work through what is happening. I had an advocate working with me for a while. It helped so much. I want that again, but the advocacy service don't have the resources to offer it to me in an ongoing way.*
>
> *Everything is short term, rather than offering me the ongoing help that I need to get through this period of time/ to let things get better.*
>
> *I'm struggling financially and life would be better if I could work, but I need help to get back into the workforce, and I can't manage adding another service at the moment"*
>
> ADACAS Client

ADACAS believes that support coordination (including case management for people whose needs are the most complex or when in crisis (whether mental health or other crises)) should be available from skilled services in an ongoing (and capacity-building) way to all people with complex needs (regardless of the service systems that they need to be interacting with). This process would require production of a client-driven plan. We recommend that support coordination for people with complex needs or in crisis should differ from the NDIS defined and funded Coordination of Supports, where hours are allocated in advance, and then further bureaucratic processes required to make adjustments to the funding levels each time this is needed. Instead support coordination services and clients together would have greater flexibility about how many hours are needed in creating the most significant positive difference for the vulnerable person involved.

- Gap in support for mental health impacts of people living with chronic illness/chronic pain.
  There is substantial evidence[30] that chronic pain impacts mental health but access to tailored mental health and other supports is incredibly limited and insufficient. Many people who experience chronic pain and chronic illness are in considerable need of mental health support[31].

- Interface issues/"silos" with NDIS:
  ADACAS is aware of ongoing tensions between the NDIA and other service systems (especially Health and Education) with regards to the perceived boundaries of areas of responsibility ("interface issues"). Given that it is hard for the service systems to clarify boundaries, there is additional and profoundly negative impacts for individuals experiencing disability and/or mental illness trying to access vitally needed support.

  As a service supporting people with mental illness appeal NDIS decisions, it has also been our experience that the NDIS appeals system disadvantages people with psychosocial disability, in that the nature of the disabilities can often mean that a person with mental ill health is unable to manage going through the appeals processes (which means that they are sometimes unable to adequately test NDIS decisions). It is also unfortunately our experience that involvement in the NDIS appeals process can have significant and adverse effects on the mental health and wellbeing of individuals.

  > *"I thought I could – but I can't do this. I can't appeal to the AAT to get NDIS entry. I can't put myself or my family through it. It is hard enough living with mental illness and suicidal thoughts without all of these appeals processes just to try and get the help"*
  >
  > ADACAS Client

- Need for Trauma informed care:
  There is a lack of clinical treatment and support available for people who have experienced trauma. There is additionally, a significant need for improved trauma informed care across services (within health and beyond), such that people are not repeatedly experiencing further trauma by virtue of interacting with service systems. We endorse the comments made by the Blue Knot Foundation about the need for all services to be trauma informed[32].

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[30] Burke, A; Mathias J; Denson, L. (2015) Psychological functioning of people living with chronic pain: A meta-analytic review, *British Journal of Clinical Psychology*, accessed via: https://doi.org/10.1111/bjc.12078

[31] Pain Australia (2017), *Mental health a big issue for people living in pain, but not much help in sight*, media release, 10 October 2017, https://www.painaustralia.org.au/media/newsletters/issue-75/mental-health-a-big-issue-for-people-living-in-pain

[32] Blue Knot Foundation (2018), *Talking about Trauma, Guide to Conversations and Screening for Health and Other Service Providers*, Lodged as a Submission to the Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health, accessed on 18 April 2019, https://www.pc.gov.au/__data/assets/pdf_file/0019/239014/sub047-mental-health.pdf

- Service gaps – need for an increase in the availability of independent advocacy support:

  Independent professional advocacy can be an important safeguard to seek to ensure that the voices of people with mental ill health are heard, their rights are respected, and that people have access to the services that meet their needs.

  There continues to be high demand for advocacy support from people with mental ill health, and increased funding is both warranted and a cost effective investment.

  An independent cost benefit analysis commissioned by the Disability Advocacy Network of Australia (copy attached: Appendix 1) has demonstrated that each dollar spent by independent disability advocacy agencies, delivers $3.50 in benefits[33]   We thus encourage continued and increased investment in independent professional advocacy for advocates to work with people with mental ill health.

- Service gaps: PHAMS / PIR funding / Community organisation support for people with more complex needs

  Peer Helpers and Mentors Program (PHAMs) and Partners in Recovery (PIR), offer vital services to those that they support and psychosocial support programs should continue to be funded in an ongoing way beyond 2020. ADACAS contends that there needs to be a return of flexible funding within the PIR program, such that there are ways to resolve immediate issues causing high levels of distress to clients.

  Whilst the newest psychosocial support program: the National Psychosocial Support Measure is welcomed - in the ACT, this program seems to be offering short term assistance only, and to be being targeted to those with less rather than more complex needs. There is an ongoing need for support for those with more complex needs.

- Service gaps: funding for volunteer programs (Red Cross Mates / Red Cross Social Inclusion / Vinnies Compeer / etc.)
  Volunteer programs (or an experience of volunteering) can make an immense difference to someone's experience. Given the widely recognised benefits of greater social inclusion, funding to operate volunteering programs (and to facilitate opportunities where support is needed for a person with mental ill health to themselves volunteer)

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[33] Disability Advocacy Network of Australia (DANA), *Independent Cost Benefit Analysis of Australia's Independent Disability Advocacy Agencies,* viewed on 5 April 2019, accessed online at
https://independentadvocacy.org.au/upload/files/CBA-IndependentAdvocacy_Summary-pdf.pdf

- Supported decision-making

    If equitable access to services is to be achieved then reasonable and necessary accommodations must be made by services[34].. In particular, those rarely considered in access supports are those with cognitive impairment, psychosocial disability or coexisting features of these. Supported decision making is often vital to facilitate inclusion and access to support[35], and needs to be available in the same way a ramp is for physical access[36]

Recommendation 10: ADACAS recommends that the Australian government increase funding person-centred coordination and recovery support, and initiatives which promote social participation and inclusion (and trauma informed approaches) for people with mental ill health and people with complex needs, commensurate with the level of need in the community.

Recommendation 11: ADACAS recommends an increase in the funding for individual advocacy support for people with mental ill health and people with complex needs.

i. Social Participation and Inclusion

Population sub-groups that are at increased risk of mental ill-health as a result of social isolation or exclusion tend to include people with one or more of the following identities or experiences (in no particular order):
- Mental ill health
- Disability
- Cognitive Impairment
- Chronic Illness
- People from Cultural and Linguistically Diverse (CALD) backgrounds
- People from Aboriginal or Torres Strait Islander backgrounds
- People who identify with one or more of LGBTQI identities
- Experiences of trauma or abuse (in childhood)
- Experiences of trauma or abuse (family violence)
- Being a victim of crime (including of abuse)
- Refugees / asylum seekers
- Carer status (all carer groups, including young carers)
- People on limited incomes (e.g. people in receipt of Centrelink pensions such as Newstart and the Age pension)
- Homelessness
- Having multiple areas of vulnerability

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[34] Australian Law Reform Commission (2014), *Equality, Capacity and Disability in Commonwealth Laws (ALRC Report 124),* Sydney Australia, https://www.alrc.gov.au/sites/default/files/pdfs/publications/alrc_124_whole_pdf_file.pdf

[35] Davidson G, Kelly B, Macdonald G, Rizzo M, Lombard L, Abogunrin O, Clift-Matthews V, Martin A, (2015), 'Supported decision making: A review of the international literature', *International Journal of Law and Psychiatry*, Volume 38, 2015, Pages 61-67, https://doi.org/10.1016/j.ijlp.2015.01.008

[36] Arstein-Kerslake A, Watson, J, Browning M, Martinis J, Blanck P (2017), 'Future Directions in Supported Decision-Making', *Disability Studies Quarterly,* Volume 37, No 1, viewed in April 2019, via http://dsq-sds.org/article/view/5070/4549

j. *Justice*

People with disability and mental ill health often experience significant challenges in accessing adequate support and reasonable accommodations in court and justice processes, before and whilst in custody[37]. The recent ACT Government report "Towards Disability Justice in the ACT" summarises a wide variety of gaps in the systems that contribute to people with disability (and people with mental ill health) finding themselves incarcerated: "People with disability are often invisible to the system, their needs go unrecognised and accordingly reasonable accommodations are not provided to assist them"[38] ADACAS is aware of people with mental ill health who were engaging with justice, housing, policing, and other support services however still did not have key needs met which otherwise could have opened alternate pathways beyond custody. A large amount of work continues to be needed at the interfaces between mental health, disability and justice systems to enable access to justice and procedural fairness for people with mental ill health.

Recommendation 12: ADACAS recommends early intervention, and to enable more equitable outcomes from the justice system for people with mental ill health.

k. *Child Safety*

ADACAS has worked alongside people with mental ill health, and people with disability who are involved with child protection over many years. In our experience, the best results are achieved in instances when parents with mental illness (or disability) who are involved with Child Youth and Protection Services (CYPS), also have an independent professional support person (who is familiar with CYPS and legal processes) funded to support the parents the entire way through the process. We have observed this helps to address power imbalances and improves outcomes for parents, for children and for CYPS workers, even in situations where the final decision is that a child should go into out of home care. At the present time, there is insufficient advocacy funding for independent support to be available to parents with mental illness or disability engaging with the child protection services, and we urge urgent funding to allow for this support to be made available. Recent Australian Law Reform Commission (ALRC) recommendations also note the value of support for families going through family law processes in improving child safety outcomes[39].

Recommendation 13: ADACAS recommends alternative processes to adversarial court processes when at all possible (i.e. mediation, family group conferencing, and a restorative justice approach), and that people who are vulnerable have additional independent support made available when needed to enable equitable participation.

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[37] ACT Government (2019), *Towards Disability Justice for the ACT: Summary of Research and Consultations 2019* viewed online 2 April 2019, https://www.communityservices.act.gov.au/disability_act/towards-disability-justice-in-the-act

[38] ACT Government (2019), *Towards Disability Justice for the ACT: Summary of Research and Consultations 2019*, page 8, viewed online 2 April 2019, https://www.communityservices.act.gov.au/disability_act/towards-disability-justice-in-the-act

[39] Australian Law Reform Commission (ALRC) (2019), *Family Law for the Future – An Inquiry into the Family Law System: Summary Report*, ALRC Report 135, March 2019, page 33, viewed online in April 2019, via: https://www.alrc.gov.au/sites/default/files/alrc_report_135_summary_report_web_0.pdf

l. Education and Training

An independent review into students with complex needs and challenging behaviours, was conducted by Professor Anthony Shaddock and team and the report "Schools for All Children and Young People" was published in November 2015[40]. All 50 recommendations were subsequently agreed to by the ACT Government and projects implemented to improve systems. ADACAS supports the need to sustain inclusivity and support for all children who experience mental ill health.

Recommendation 14: ADACAS recommends ongoing monitoring of and continued efforts to improve education experiences for (and counter discrimination and stigma against) students with mental ill health and disability.

m. Government-Funded Employment Services:

ADACAS seeks and looks forward to continuing improvements in the support available to people with mental ill health from Disability Employment Services and in workplaces. Currently the bureaucratic barriers to entry to Disability Employment Services (Centrelink processes) can make it harder for people with mental ill health to access these supports. The transition to the NDIS has additionally sometimes meant increasing complexity for those receiving or seeking to access employment support.

n. Mentally Healthy Workplaces

The education and training opportunities that have been afforded people with mental ill health throughout their lives can affect the types of job opportunities available to them, and that the person's circumstances, the type of work can also affect the types of adjustments that are needed. In addition an employer's awareness of mental health, their ability to create a culture where mental health is understood and supported, and (in conjunction with the employee) employing reasonable adjustments when required, can make an immeasurable difference.

It is imperative also for there to be ongoing and concerted efforts to address stigma, preconceptions and the discrimination that occurs in workplace and recruitment decisions to avoid situations where employers choose not to employ a person with mental illness due to ill-informed fears about the adjustments that might be required. Awareness raising, mental health and wellbeing strategies need to become as normalised in the workplace as leave applications as quality assurance processes.

It is imperative also to both acknowledge and seek to address the structural factors which can affect economic participation of people with mental illness and carers (i.e. the lack of job opportunities, and a lack of recognition of the value of diversity, also discrimination). Although discrimination has been widely acknowledged and addressed largely through preventative and awareness raising efforts for many years now, there is little evidence that persistent offenders whose workplaces perpetuate discrimination face any significant sanction, and ADACAS would be keen to see

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[40] Shaddock A, Packer S, & Roy A (2015), *Schools for All Children & Young People: Report of the Expert Panel on Students with Complex Needs and Challenging Behaviour*, November 2015, accessed in April 2019, via https://www.education.act.gov.au/__data/assets/pdf_file/0003/856254/Attach-4-Expert-Panel-Report-Web.pdf

acknowledgement of this and some discussion about whether penalties for discrimination might also assist in changing workplace cultures and practices.

In terms of workplace adjustments - whilst we are aware of an example of excellent practice (outlined over the page) – we would also question – how many workplaces in which a person with mental ill-health is working, would have the knowledge, flexibility and wherewithal to offer these?

An organisation assisted a person with disability (who also experienced chronic illness and mental ill health), by implementing the following list of strategies:

- *Working from home arrangements approved (including permission to work from bed when needed).*
- *Access to personal leave without needing a doctor's certificate for each day away.*
- *Flexible working hours, such that person can work at times that best suit health*
- *Administrative support was recruited/arranged.*
- *Preparedness for the organisation to manage days with no telephone contact (only written correspondence) due to employee health*
- *Educated organisation on mental ill health*
- *Travel arrangements made around health needs, support workers offered when needed.*
- *Planning meetings calls, workshops etc. around health/wellbeing and medication needs*
- *Consideration regarding time off required (including in advance in special circumstances)*
- *Purchase of equipment and resources to assist the worker.*

We are very aware that adjustments need to be suitable for the person, their role and the organisational environment, that there are many organisations that would need considerable funding and training (and ongoing mentoring) to make it possible for them to offer suitable adjustments.

In response to the suggested possibility of strengthening the incentives which employers face to make their workplaces more mentally healthy – there are some good initiatives suggested, but that actual supports, rather than solely financial incentives, are required to make these changes. There are at present also some gaps in the funding available to assist businesses to make certain types of adjustments (for example, depending on the nature of the person's situation, there is not always funding available to allow for people to have a support person to assist the person with learning the requirements of the role).

Recommendation 15: ADACAS recommends that there be additional initiatives and incentives to support mental health in workplaces and to recruit, support and retain people with mental ill health, people with disability and carers in the workplace.

o. *Coordination, Integration and Funding Arrangements*

Despite the efforts of many and whilst there is considerable goodwill and desire for collaboration and coordination, coordination between mental health services and supports across health and non-health sectors and different levels of government has happened often only in limited ways, often restricted by the pressures of service delivery.

Services need to be adequately resourced such that they can respond to need and additionally collaborate/ coordinate effectively. Delivering the funding of services primarily through Primary Health Networks (PHNs) runs the risk of prioritising a medical model/ approach to mental health. This in turn increases the risk of disenfranchising service providers which are offering alternate (equally evidence-based and important) supports, and the people with mental ill health who are seeking or needing alternative (non-medically oriented) models of support or care.

We suggest it would be good to embed experience in coordination and collaboration across disciplines from undergraduate education and training offered to people who will be working in the sector (students studying medicine, nursing, social work, OT, physiotherapy, law, public policy etc. at university could be collaborating in teams across their universities or colleges from early in their studies).

Some drivers of growth of mental health expenditure in Australia have included:

- Raised awareness and concern re suicide and depression (and mental health in general) and desire for support accordingly.
- Raised understanding of and awareness of the impacts (and prevalence) of trauma and abuse
- Raised awareness and concern re mental health impacts for younger people
- Raised awareness of concern of the impact of substance misuse on mental health, and an increased understanding of the impacts for first responders (police, ambulance, but also health and community services).
- An additional driver of a growth in services is the fact that many people who need more fulsome support and treatment (e.g. quality treatment for severe depression, evidence based intensive treatment for people with personality disorder diagnoses, support to recover from PTSD etc.) are not receiving it, which is meaning that impacts can have continuing high impacts.

Recommendation 16: ADACAS recommends that resourcing levels for the sector be at a level where services can both respond to need and collaborate more easily.

5. Conclusion

ADACAS would like to point out, in conclusion, that there have been many systems and services and factors described through the Productivity Commission's Issues paper, that contribute to mental ill health, and where improvements could effect significant positive benefit.   It is our experience that people rarely experience these factors one by one – instead many of the factors occur simultaneously. It is important to recognise this, and to ensure that systems have the flexibility to respond in a person-centred way, such that matters can be responded to effectively and ideally in the order and at the pace that the person most affected desires.

Please note that all case studies that ADACAS has used to illustrate the points made throughout the submission have been altered to protect the identities of the individuals involved.