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Wellways Australia submission to the Productivity Commission Inquiry into Mental Health

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"People don't need more referrals to mental health services, they need referrals to life and community."
The Strengths Model, C Rapp, R Goscha, Oxford University Press, 1996

Executive Summary

The ineffectiveness of Australia's mental health system, fragmented and dominated by a medical model, has major adverse economic impacts – with low economic participation and productivity for people who experience mental illness and their families. 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 community inclusion initiatives.

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. 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 community-inclusion initiatives.

An array of stakeholders – individuals with a lived experience of mental 'ill' health themselves, their families and friends, those who provide supports within human services agencies, funders, and, importantly, the wider community – can follow these principles to move community inclusion from a vision to a reality.

Key to establishing community inclusion are the opportunities mental health service consumers must interact with citizens who do not have an experience of poor mental health. This submission highlights the opposing endpoints on this dimension, i.e., versus participation that primarily promotes interactions with other people who do not experience poor mental health (association).

Wellways believes strongly that peer support is a recognised exception to this, but individuals also benefit from opportunities to associate with people with whom they share other interests and identities. Throughout this submission, we provide ample evidence that a peer support workforce providing conventional community managed (CMO) mental health services can be effective in engaging people into care, reducing the use of emergency rooms and hospitals, and reducing substance use among persons with mental health issues.

When providing peer support that involves positive self-disclosure, role modelling and conditional regard, the engagement of a peer workforce has also been found to increase consumers of mental health services sense of hope, control, and their ability to effect changes in their own lives; increase their self-care, sense of community, belonging and satisfaction with various life domains; and decrease their level of depression and psychosis.

Peer support is shown to be particularly effective in helping people identify areas where they wish to participate more in their communities, which could be especially challenging after many years of possibly being told that community inclusion was not possible. Peers have also been known to participate in certain activities in the community with someone they are supporting to decrease stress about going to the activity alone or to teach them how to get to the activity.

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.

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

- 1,800-plus staff across over 100 offices throughout eastern Australia, from Tasmania to Queensland.
- 158 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 40 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 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 in evidence of what works, delivering proven services and supports with measurable outcomes. We support people to manage their mental health, so they can survive 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 hospitals is not always the solution to rising mental health issues in Australia. Instead, it can mean addressing fundamental issues such as housing, support, jobs, education and meeting basic rights. 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, 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 distinction Wellways has conventionally made.

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 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." *

*Mental health and the NDIS https://www.ndis.gov.au/understanding/how-ndis-works/mental-health-and-ndis

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 in isolation.

Recovery in the community mental health context refers to the process of changing the client'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 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

Around one in five Australians experience mental health issues at some stage in their life. Mental health issues accounts for 13 per cent of the total burden of disease in Australia, and is the largest single cause of disability, comprising 24 per cent of the burden of non-fatal disease. Around 778,000 Australians experience severe mental health issues[1] and approximately 64,000 have enduring and disabling symptoms with in-community multi-agency support needs.[2]

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 Australian and state/territory governments as well as the non-government sector, all deliver programs for people with mental health issues and their carers. Building a coherent system of support is a challenging task.

[1] Based on a population of 25 million in the September 2018 quarter http://www.abs.gov.au/AUSSTATS/abs@.nsf/mf/3101.0 and the estimate of 3.1 per cent of the population have a severe disorder in Department of Health. *Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programs and Services*. 2015. Page 25.

[2] Productivity Commission. *NDIS Costs Study Report*. October 2017. Page 31.

One of the most consistent themes fed back to Wellways throughout our network of programs and offices is that care for the most vulnerable people with severe and persistent mental health issues is not adequately integrated or coordinated, and people with complex needs often fall through the resulting gaps.

Community managed (CMO) mental health services are a vital part of the mental health system, providing care in a community setting to people with severe mental health issues and a so-called psychosocial disability. CMO mental health services 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 and time away from work.

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,*[3] 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.
- 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

[3] 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 – 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 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

Well Together report available here: https://www.wellways.org/about-us/publications

Community-based mental healthcare

CMO mental health services are a vital part of the mental health system, providing care in a community setting to people with severe mental health issues and a psychosocial disability. Community mental health services 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 and time away from work. Community-based collaborative care models build 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.[4]

Housing First

The Housing First model is used by Wellways in several homelessness programs. Under the model people are provided with 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.

Wellways champions housing as a human right as one of its advocacy platforms. Having a home, where one is safe, secure and sustainable is the foundation to positive health, family and community connections. Housing First is emerging with significant cost and health outcomes – Professor David Dunt discusses the correlations between internationally evaluated programs such as: The at Home/ Chez Soi – Canada and Pathways to Housing – Housing First in the USA and Australian Housing first programs.5

Additional and numerous randomised control trials of Housing First Programs have been run internationally and nationally for people experiencing homelessness. Results of such trials indicate higher housing retention for people supported through Housing First support models, rather than traditional housing program models.[6] Such success evidences strong support for the expansion of such housing models across Australia to reduce homelessness.

[4] Mental Health Australia and KPMG, (2018) Investing to save: The economic benefits of investment in mental health reform Final Report, Canberra, Australia.
[5] 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.
[6] Padgett, D.K., Henwood, B.F. and Tsemberis, S.J., (2016) Housing First: Ending Homelessness, Transforming Systems and Changing Lives, New York, USA.

For more on the International findings of Housing First visit:
https://journals.sagepub.com/doi/abs/10.1177/1049731505282593;
https://housingfirsteurope.eu/

Peer Support

As a leading cause of disability with rising prevalence, tackling mental health issues requires a new, expanded response as the traditional medical model struggles to cope. 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 ill health.

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.

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.

Workforce planning will need to keep pace with these developments, and new approaches will be 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.

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

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 there are others who could play a greater role."

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

> "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, with provides hope and model 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."

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. [8]

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.[9] 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.[10] Similarly, data from six studies in the United Kingdom produced estimates of the number of hospital-bed-days saved per

[8] Davidson, L., Bellamy, C. and Guy, K., (2012) Peer support among persons with severe mental illness: A review of evidence and experience, World Psychiatry, 11(2):123–128.
[9] 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., (2018) Revisiting the Rationale and Evidence for Peer Support. Psychiatric Times, 35(6).
[10] Mental Health America. (2018). Evidence for Peer Support, New York, USA.

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).[11]

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.

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. 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 workers, an estimated 240,000 Australians 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,[12] when peers work in traditional case management roles[13] and for people who are homeless,[14] 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

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

[12] 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.

[13] 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.

[14] 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.

- 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
- leads to reduced depression, heightened self-esteem and self-efficacy, and improved quality of life for peer workers.[15]

> *"Peer workers understand certain things others don't - you know you are both travelling on the same path."* - Wellways participant

Peer support can be highly effective in reaching people with mental health issues and psychosocial disabilities who may be alienated from 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.

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

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

individualised support to build tenancy literacy and links to health services and community, more long-standing health and housing outcomes can be achieved.

Support for people experiencing mental health issues 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 navigate the system. Developing natural support 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. Moreover, 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.

Throughout the 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 holistically intervenes 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,[16] per day for people engaged in private rental through the Doorway program. This cost benefit analysis included economic costs associated with utilisation of health, crisis and social housing systems being accessed by this population group, and others experiencing homelessness in the community.[17]

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

[16] NOUS Group, (2014) Formative Evaluation Report, Doorway Program, Melbourne
[17] NOUS Group, Op Cit

indicating a $3,688 cost saving to Government per participant annually. This is when compared to other social and public housing models.[18]

Evaluation of the Doorway pilot program indicated that 93 per cent 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).

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. Studies by Professor Patrick Corrigan of the Illinois Institute of Technology, USA,[19] have found that understanding and empathy increases substantially when opportunity is provided to learn directly from people who have a lived experience. When they hear a person's 'story' about mental health issues and recovery, their perspective shifts.

The Wellways Well Together community education program was developed according to 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

[18] , 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.
[19] Corrigan, P.W., (2002) Empowerment and serious mental illness: Treatment partnerships and community opportunities Psychiatric Quarterly. 739(3): 217-228.

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.

Social capital leads to economic capital

"There is compelling evidence that individuals who feel connected to a community of others – families and friends, co-workers and neighbours, etc. – are better able to avoid both physical illness and emotional stress and that whether this is characterized as the development of 'personal communities', 'social capital', or one connection to 'social networks – this sense of connectedness to the world around us provides emotional, material and information support that has positive impacts on the self-esteem, life opportunities and physical survival of everyone in the community."

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- Well Together blueprint, et al, p. 87

Peer Support

Professional peer work is a vital part of a good health system, offering a more equal, trusting and flexible support than many clinical health services can provide. Peer services are generally just as effective as services provided by non-peer professionals. Numerous studies have found that those working in peer-specific roles are better able to: engage people in caring relationships; Improved relationships between clients and outpatient providers, thereby increasing engagement in non-acute and less costly care; decrease substance use, unmet needs, and demoralisation; increased hope, empowerment, self-efficacy, social skills, quality of and satisfaction with life and activation for self-care. [20]

Peer education programs, for both consumers and carers, are effective as an early intervention approach, and an intervention for people with long-term mental health challenges. The consumer program is inclusive of all experiences, regardless of diagnosis. Wellways 'Building a Future' (a carer program) and 'My Recovery' (for clients) are based on international evidence about mental health issues management and recovery, as well as lived experience and peer support.

These are group programs, led by peers - and are therefore more cost-effective than one-to-one interventions and programs led by more qualified professionals. Evaluative research by Swinburne and La Trobe universities describes significant outcomes for both programs that are sustained over time.

- Outcomes for consumers include: significant improvement in the areas of mental health issues management, empowerment, general health and stigma reduction.
- Outcomes for carers include: reduction in tension, worry and distress, improvements in communication and capability, increased empathy, and a sense of not being alone.[21]

[20] 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., (2018) Revisiting the Rationale and Evidence for Peer Support. Psychiatric Times, 35(6).

[21] Aziz, Z., Riddell, M., Absetz, P. and Brand, M., (2018) Peer support to improve diabetes care: an implementation evaluation of the Australasian Peers for Progress Diabetes Program.

Peer support in suicide prevention

In supporting suicide prevention, peers can provide a more equal, trusting and flexible form of support than many clinical health services can provide. Peers focus on sharing their lived experience, rather than assessing, advising or evaluating others.

Lived experience 'contact' and 'story telling', facilitated within community based mental health promotion programs (i.e., the Well Together program) – to reduce stigma and increase acceptance and health seeking behaviours.[22]

When lived experience stories are shared in trainings for professionals, such as trauma awareness training, people are more likely to actively change their practice and helping approaches (evidence from Well Together evaluation: There is a greater 'willingness to listen and learn about many different challenges faced by members of the community' and people are more likely to 'be considerate, be with mental health affected people and have unconditional positive regard'.

Regarding co-morbidity, 'diagnostic overshadowing' is widespread. The National Mental Health Research Council's *Equally Well*[23] report found people with severe and persistent mental health issues are dying from diseases such as cancer and heart disease at a rate two to three times greater than those with the same health issues in the general population.

This happens because they are not receiving preventative screening tests or treatments. Methods to hold health care providers accountable to people's physical health needs of must be explored, whether that be through information technology, access to screening resources, oversight by peak bodies etc. It is also widely known that if psychiatric medication if not closely monitored by prescribers, severe health issues can develop as a result. *Equally Well's* "Physical Health Impacts" report insists that prescribers of psychiatric medication have a responsibility to monitor the effects of medication on a person's physical state as well as its impact on their mental wellbeing". [24]

Equally Well's "Physical Health Impacts" report; https://nmhccf.org.au/publication/physical-health-impacts-mental-illness-and-its-treatments

Health workforce and informal carers

In order to build a skilled and qualified workforce to suit the needs of all mental health service recipients, the community managed mental health sector has advocated for a voluntary minimum qualification. Studies have argued that for psychosocial disability and

[22] Corrigan, P.W., (2002) Empowerment and serious mental illness: Treatment partnerships and community opportunities Psychiatric Quarterly. 739(3): 217-228.
[23] *National Mental Health Commission, (2016) Equally Well, Improving the Physical Health and Wellbeing of People with Mental Illness in Australia, Canberra.*
[24] National Mental Health Commission, (2016) Equally Well, Improving the Physical Health and Wellbeing of People with Mental Illness in Australia, Canberra.

recovery support work, the minimum qualifications should be a Certificate IV in Mental Health or a Certificate IV in Mental Health Peer Support work or equivalent.[25]

An example of a suggested entry pathway for recovery support work (other than general administration and university qualified entrants) is proposed by the Mental Health Community Coalition of the ACT in its document: A Real Career: Workforce Development Strategy.[26] The strategy offers two pathways for people who do not follow an administration or 'clinical' (university qualified) path.

The first is for 'recovery practitioners' who enter as trainees (mandatory completion of the Certificate IV in Mental Health) or appropriately qualified graduates. The second path is for 'peer support practitioners'; an identical career progression to the aforementioned but positions are held by peer workers (presumably completing the Certificate IV Mental Health Peer Work). In general, minimum workforce entry requirements like those outlined above tend to restrict workforce growth, which may explain why in the United Kingdom rapid workforce growth was fuelled by a decrease in the number and level of qualifications in the workforce.[27]

Regardless of the type of worker, the mental health system must accommodate rapid expansion and include development opportunities for the workforce.

The impact of mental health crises and subsequent experiences of disability and exclusion on a family can result in individuals being thrust into 'caring' and 'cared for' roles. These impacts may also result in a sense of loss and grief as a 'parent' or 'partner' role is obscured and in a deterioration of the mutuality inherent in healthy family relationships.[28] Further studies challenge the notion of the 'static and enduring role of caregiving' and suggest that families need support to regain hope, reconnect, overcome trauma and make the journey 'from carer to family'.

The evaluation of Building a Future, a program developed by Wellways, found positive outcomes from a family peer education program where families, friends and carers are supported to gain knowledge and skills in relation to their caring role and supported to focus on their own wellbeing. The group sessions for family members resulted in less worry, tension, and distress, which was maintained at three and six month follow-up. The end result of such interventions is likely more energy and community engagement that can contribute to the community inclusion of their loved one.

Training and Peer Supervision

Consumer choice and control has been recognised in the development of the NDIS. Similarly, responsiveness and consumer control in trauma-informed approaches should be considered when designing negotiated and flexible trauma-informed response services. Importantly, there is a need to place survivor knowledge at the heart of the development and implementation of trauma-informed approaches.

[25] Mental Health Community Coalition, 2015; Community Mental Health Australia, 2012
[26] Mental Health Community Coalition of ACT, 2012
[27] Gianfrancesco, P., (2014) NDIS & learning from the UK experience of personalisation: A provider perspective, Presentation.
[28] Lovelock, R., (2015) Developing a strategy for the family/carer workforce in Victoria, Melbourne.

This is because it is survivors who understand, through lived experience, what heals and what harms, and the importance of reversing 'power over' abuses.[29]

Wellways recommends trauma informed practice/trauma awareness training as being necessary for general practitioners and allied physical health practitioners to inform them of the evidence base that links early childhood and 'life' traumas with the development of mental 'illness', suicidality and serious physical health issues" (evidence is shown the Early Adverse Childhood Experiences (ACE) study)[30] and to provide skills in working effectively with people who have experienced trauma.

Given the centrality of trust and empowerment to healing for trauma survivors, it is vital that the use of co-production methodologies shape the research and service development agenda in this area.

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 Australia[31] 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:

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."[32]

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. [33]

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.

[29] Sweeney, A. and Taggart, D., (2018) (Mis)understanding trauma-informed approaches in mental health, Journal of Mental Health, 27:5, 383-387.
[30]Anda, R., Felitti, V., Bremner, D., Walker, J., Whitfield, C., Perry, B., Dube, S. and Giles, W., (2006). The Enduring Effects of Abuse and Related Adverse Experiences in Childhood: A Convergence of Evidence from Neurobiology and Epidemiology. European Archives of Psychiatry and Clinical Neuroscience. 256. 174-186.
[31] Gooding, P., Anderson, J. and McVilly, K., Disability and social inclusion 'Down Under': A systematic literature review
[32] Gooding, P., Anderson, J. and McVilly, K., Disability and social inclusion 'Down Under': A systematic literature review
[33] Daly, M. and Silver, H., (2008) Social exclusion and social capital: A comparison and critique, Theory and Society 37(6): 537–66.

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

- Aiding help 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. This experience includes previous delivery of Disability Employment Services (DES) through the Individual Placement and Support model and Personal Helpers and Mentors (PHaMs) employment services, accredited and pre-accredited training through our Registered Training Organisation; and ongoing research and advocacy.

This inquiry presents an 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

The Australian Government has invested significantly in the DES sector and PHaMs service. Despite this investment, employment outcomes remain poor, particularly for people with a mental health issues who make up the largest proportion of unemployed people with a disability. The recent reforms to the DES, implemented in July 2018, were aimed at addressing this poor performance.

To date, there is insufficient evidence to indicate whether these reforms have made any significant improvements to employment outcomes.

We believe the July 2018 reforms were a missed opportunity to make the systemic changes needed to improve employment outcomes for people with a mental health issue. 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 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 DES and PHaMs 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 too many
- Current employees at risk of job loss due to emerging mental health concerns.
- Families and carers.

Carer workforce participation

The present employment service system does not adequately meet the needs of families and carers. The Carers and Work program has limited scope with few programs available and only a small number of providers. Supporting families and carers workforce participation is fundamental to improving overall economic participation. It is an essential early intervention approach, ensuring families and carers social and economic wellbeing.

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.[34] 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.[35] 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.[36]

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 Local Health Districts (LHDs) and 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

[34] Salzer, M.S. and Baron, R.C., (2016) Well Together: a blueprint for community inclusion: fundamental concepts, theoretical frameworks and evidence, Melbourne, Australia.
[35] 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.
[36] 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.

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.

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.

Funding arrangements

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

(See Appendix 1: Service contacts sample)

This represents funding that our organisation has in one rural/regional district in NSW.

As can be seen, there are four different funding contracts funded by three funders: NSW Health, the local PHN and the LHD. The funding is targeted substantially at the same cohort.

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 in Queensland 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, the tender for the Supporting Recovery Service in Table 1, 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.

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

Because of the nature of Commonwealth funding to 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, tender writing etc.

Recommendations

The three paradigms supporting the Wellways community inclusion approach – human rights, economic and moral development, and personal health – each acknowledge that a 'social model of psychosocial disability' is essential to an understanding of the lives of those with lived experience of poor mental health.

Its analysis – that disability is the product of the reluctance of social systems to accommodate, welcome and embrace individuals with impairments to fully participate in the community – draws attention to the array of environmental barriers to community participation that remain either unrecognised or unchanged. In that light, it becomes critical that rehabilitation services not only provide individuals with the supports required to participate in everyday activities, but also address those very environmental barriers which exclude, isolate, and devalue individuals with differences.

Although there are multiple barriers, the most serious environmental barriers consistently identified in mental health literature are: 1) individual disempowerment;[37] 2) sustained poverty;[38] 3) inadequate transportation;[39] and 4) public prejudice and discrimination[40] – a set of perplexing environmental barriers that are deeply intertwined with one another.

There is, therefore, much to be done by both consumers, service providers and governments, together, to effect significant change in each of these arenas.

The provision of flexible and innovative funding processes (for example, the NDIS Information Linkages and Capacity Building program) can lead to positive engagement by some organisations to engage people generally experiencing social exclusion and discrimination. In 2017 Wellways was commissioned by National Disability Services, Australia's peak industry body for non-government disability service organisations, to design a project to meet the needs of LGBTIQ+ mental health service consumers by providing a LGBTIQ+ workforce who can draw on lived experience expertise.

The project, Out Together, draws on established evidence-based approaches in peer support within the mental health sector, applies these more broadly to people with a disability, and targets them specifically at a marginalised group – service consumers who identify as LGBTIQ+. This is a new approach to offering support to this group of participants.

[37] Chamberlin, J., (1997) A working definition of empowerment, Psychiatric Rehabilitation Journal, 20, 43–46.
[38] Elwan, A., (1999) Poverty and disability: A survey of the literature, Washington, DC: Social Protection Advisory Service.
[39] Krahn, G. L., Walker, D. K. and Correa-De-Araujo, R., (2015) Persons with disabilities as an unrecognized health disparity population, American journal of public health, 105(S2), S198-S206. Sherman, J. and Sherman, S., (2013) Preventing mobility barriers to inclusion for people with intellectual disabilities, Journal of Policy and Practice in Intellectual Disabilities, 10(4), 271-276.
[40] Corrigan, P.W. and Matthews, A., (2003) Stigma and disclosure: Implications for coming out of the closet, Journal of mental health, 12(3), 235-248.

See Innovative Workforce Fund Final Implementation and Reflection Report: https://media.wellways.org/inline-files/NDS-report.pdf

Wellways acknowledges the importance of outcomes measures and believes that there exists an opportunity to embed and improve data collection, program performance and evaluation tools within the mental health system and encourage best practice in mental health outcomes and clearly define national indictors that:

- include co-design and co-production of outcomes measures between service users, service providers and funders
- include collection of different data sources such as (a) individual qualitative measures related to personal recovery outcomes and satisfaction, (b) high level systemic and community measures and (c) evaluation of socio-economic impacts
- align with an aspirational long-term vision that reflects the underpinning values
- correlate with clear targets
- are derived from latest research and lived experience expertise
- are measurable, reportable and indicate progress across key areas of reform
- drive continued improvement and reform of services
- support a more targeted, evidence-based direction of funds.

Beyond outcome measurement, Wellways strongly believes that measuring progress according to the service delivery model must involve ongoing consultation and feedback from families, carers and consumers. This should not be limited to the experience of any one service, but the mental health system as a whole.

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Appendix 1: Service contracts

Program	Target	Funder	Term	Revenue	Payment terms	Reporting
Housing and Support Initiative (HASI)	Community -based non-clinical supports for people 18-64yrs with severe and enduring mental illness	NSW Health	3 years	$921,659 per annum	Quarterly in advance	Quarterly Service Date Reports Monthly Minimum Data Set Annual Activity Report Standard Board Certified Statement of Revenue and Expenditure (six-monthly) Independent Audit Report Statement with Audited/Reviewed Financial Statements (financial year)
Enhanced Adult Community Living Supports (ECLS)	Community -based non-clinical supports for people 18-64yrs with severe and enduring mental illness	NSW Health	3 years July 2016-June 2019 with two further 3-year options	$1,215,348 per annum (+$137,597 establishment)	Quarterly in advance	Annually - Financial report: Standard Management Board Certification by Service Provider Office Bearers Independent Audit Report Statement with Audited/Reviewed Financial Statements (financial year) Annual Activity Report 15 Service Performance Measures
Suicide Prevention Service	Individuals at risk of suicide	Primary Health Network	1 year July 2017-June2018 Subsequent 1 year contract July 2018-June2019	$781,500 $724,220	Quarterly in advance – provided all deliverables have been met	At commencement: • Establishment Plan • Communication and service promotion plan • Professional development plan for Support Coordinators Establishment Report (end Q1) Quarterly Report and Financial Report (end Q2) Quarterly Report end Q3

Program	Target	Funder	Term	Revenue	Payment terms	Reporting
						Quarterly Report and Audited Financial Report end Q4 14 KPIs
Supporting Recovery Service	Community -based non-clinical supports for people 16yrs - old with moderate to severe mental illness and high levels of psychosocial impairment in three remote towns Not receiving ECLS, HASI or NDIS supports	Local Health District	3 years January 2019-December 2021 2 x 1-year extension options	$219,635 per annum (Town 1 $55,600; Town 2 $85,035; Town 3 $79,000)	Quarterly in arrears – provided satisfactory performance as per KPI	Quarterly Performance Reports with 6 KPIs Annually- Independent audited financial statement acquittal
Psychosocial Support Initiative – Well Connected	Community -based non-clinical supports for people 18-64yrs with severe and enduring mental illness	Primary Health Network	2 ½ years	$785,000 Nov 2018 - June 2021	Quarterly in advance subject to required reports being received and approved by PHN	At commencement: • Annualised budget • Annual Activity Plan including risk management plan and establishment plan • Communications and Marketing Plan Monthly Minimum data set Quarterly Report 6-monthly Financial Report 6-monthly Clinical File Audit Report Audited Financial Report (financial year)

Choose different, choose **wellways**

At Wellways, our experience in in both mental health and disability allows us to provide supports and understand your physical and emotional needs.

OVER 40 YEARS OF EXPERIENCE

Wellways has been working for people with mental health issues and disabilities for more than 40 years.

MENTAL HEALTH SPECIALIST

We have experience in developing and delivering many mental health services and programs. We understand the challenges and complexity of mental health issues for individuals and families.

COMPLEX NEEDS

We have experience and trained staff to work with people with complex needs and multiple diagnosis.

WORKERS WITH LIVED EXPERIENCE

Many of our workers have 'been there' and can relate. At Wellways we value personal experience and believe this contributes to the depth of our programs.

WORKERS WHO IDENTIFY AS LGBTIQ+

Our Out Together program aims to meet the needs of NDIS participants who identify as LGBTIQ+ by providing them to access to LGBTIQ+ peer workers.

Contact Wellways Helpline on **1300 111 500** to find out about services and supports available to help you achieve your goals.

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Wellways acknowledges Aboriginal and Torres Strait Islander People as the traditional owners and custodians of the land on which we live, work and play and pays respect to their Elders past, present and future.

wellways.org | 1300 111 400

WELLWAYS AUSTRALIA LIMITED
ABN 93 093 357 165
Corporate Office
276 Heidelberg Road Fairfield Victoria 3078
PO Box 359 Clifton Hill Victoria 3068
+61 3 8486 4200