**SA** Mental Health Commission

Submission 477 - SA Mental Health Commission (SAMHC) - Mental Health - Public inquiry

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# Overview

The SA Mental Health Commission (SAMHC) was established by the South Australian Government in October 2015.

The initial focus of the SAMHC was to develop the South Australian Mental Health Strategic Plan 2017-2022. The Plan is built on the powerful feedback, stories and views of over 2200 South Australians of all ages across metropolitan and country SA during wide-ranging consultations.

The South Australian Mental Health Strategic Plan 2017-2022 was endorsed and released by the South Australian Government in December 2017.

In implementing the Plan, the SAMHC is uniquely placed to work in strong partnership with people with lived experience and their carers, the community, service providers, government, non-government and private organisations, industry, clinicians, and academic institutions. The Commission also works across government agencies including housing, health, education, employment, justice and disability.

The SAMHC ensures a strong community voice at both the state and national levels. Submissions to national inquiries are one way in which the SAMHC achieves this.

It was in this regard that the SAMHC and Productivity Commission met between December 2017 and January 2018 to discuss how the SAMHC can be involved in supporting the Productivity Commission's Inquiry into Mental Health.

During these meetings it was agreed that the SAMHC could assist the Productivity Commission in their inquiry through facilitating community engagement activities by leveraging off the SAMHC's existing community networks.

Subsequently, in March 2019 the Productivity Commission met with the SAMHC's Youth Advisory Group (YAG) and attended a culturally and linguistically diverse (CALD) community forum where 29 different multicultural groups were represented.

The groups discussed mental health in terms of its impacts on the areas outlined in the Productivity Commission's issues paper, as well as looking at what's working now, what's missing and what needs to happen in the future.

The responses provided to the Productivity Commission at these forums have been collated by the SAMHC, as well as insight from the SA Mental Health Strategic Plan 2017-2022 and other resources. This written submission provides a summary of that information.

# Structure of this submission

There are three distinct categories of information presented in this submission, as defined below. Content in each of these categories has been arranged to align with the Productivity Commission Issues Paper *The Social and Economic Benefits of Improving Mental Health*. Note that not all categories defined below resulted in information relevant to all topics outlined in the Productivity Commission Issues Paper.

## *Key findings from the 2017 SAMHC community consultation*

In June 2017, the SAMHC released a summary of key findings identified through research, and during conversations with and submissions from over 2,270 South Australians during August 2016 to May 2017. During this period the SAMHC asked South Australians what they considered to be working with respect to mental health and wellbeing in the State, what was not working so well, and what the future might look like. Relevant insights from the community have been extracted and aligned to the key topics presented in the Productivity Commission Issues Paper.

Note that while care was taken to remove information from the 2017 consultation feedback that is now out of date, there may be some oversights.

## *Summary of information heard during consultation with the Youth Advisory Group*

On 20 February 2019, the Productivity Commission attended the regular meeting of the SAMHC's Youth Advisory Group, where members of this group were able to present their concerns and answer questions posed by the Commissioners.

## *Summary of information heard during consultation with the CALD community*

On 21 February 2019, the Productivity Commission attended a forum held in Adelaide and co-hosted by the SAMHC and the culturally and linguistically diverse (CALD) community. A diverse group consisting of 54 people from 29 different multicultural groups was represented at the forum.

# Response to the contributing components to improving mental health and wellbeing

## 1.1    Healthcare

### Key findings from the 2017 SAMHC community consultation

**People told the Commission they found it difficult to know where and how to access appropriate and timely help for mental health issues, ranging from mild distress to crisis to ongoing community support**

The Commission heard time and again that people did not know where to go for assistance with mental health concerns ranging from mild distress to crisis to ongoing community support, or that once contact was made, the service system was difficult to navigate. Over and again people spoke to the critical nature of being able to access the right support at the right time without having to knock on several service providers' doors or jump through hoops to provide the services they need. This applied to people experiencing mental distress and also to their families, carers and friends. It also applied to people working in a range of organisations who may be either managing staff experiencing mental health issues or who talk with people in their line of work (e.g. pharmacists, welfare agency staff) and who are unsure where to refer them for assistance.

Some people and service providers were seeking an easily accessible directory of services; others wanted help with navigating 'the system'. Others sought a central pathway or access point to services. Suggestions for a single access point included a single phone access line or online request that connects the person to services most suited to their needs at the time. South Australians want to be able to access the service they need irrespective of how it is being funded and by which level of government, in the case of public services. Any access point also needs to recognise that "mental health doesn't stop at 5pm on a Friday", and that 24/7 access to appropriate support is required.

In order to assist in a time of crisis, or to prevent crises from occurring, South Australians are also seeking timely access to care. Many stories were related to the Commission about people being told they would need to wait long periods of time for appointments with private or public psychiatrists or psychologists. For many South Australians, their mental ill-health became more critical during this wait period, to the point where they ended up in emergency departments. The Commission heard from many staff in public mental health services that services were stretched, but also from NGOs and other community organisations that there may be an over-reliance on health services as the 'go-to space'.

Some NGOs suggested a greater role for GPs, peer workers, or "any workforce outside health with skills in relationship building and communication who may be able to provide low intensity supports" to assist people in their communities and help prevent the need for hospital presentation or admission. These services may or may not require people to have a diagnosis of mental illness, and may allow self-referral. It was suggested that this may also free up mental health services to see more people with severe and complex mental illness, many of whom may not be actively seeking help and who may require services to reach out to them.

The Commission heard about innovative services such as the GP on campus at Victor Harbor High school where students could access GP services at school and where the counsellor could connect with students and the GP to develop a mental health plan to help young people access the help they needed.

In rural and remote communities, lack of ready access to timely and appropriate services and support for mental health issues was described as a key issue. South Australians in rural and regional areas spoke of the difficulty in accessing services that didn't exist where they lived – of having to drive 200 kms or catching expensive and inadequate public transport. South Australians told us that they had lengthy waits for the fly-in fly-out psychologist, had visits from the Child and Adolescent Mental Health Service only two days each month, had a three month wait to see the visiting psychiatrist, and that the nearest GP was 100km away. There is also a lack of accommodation options in the country particularly for those with mental illness, drug and alcohol issues, forensic history and/or intellectual disability who may need 24-hour supported accommodation. The Commission heard that poorer service access and the tyranny of distance means that people in rural and remote areas access mental health services at about one-fifth the rate of people in major cities, and these services are therefore less likely to be able to intervene early.

Various insights were provided as to how access to primary and acute mental health services could be improved in rural and remote areas. These included greater or smarter investment in incentives to attract and keep staff living in or visiting rural areas, increased use of telephone or online supports and availability of telehealth, and expansion of the National Broadband Network to ensure coverage to all areas. South Australians also advised that access to lower level support for mental health in country locations may be improved by additional training and/or utilisation of local people and professionals. This could include an expanded role and infrastructure for community pharmacists, GP receptionists, other allied health professionals, Aboriginal Health Workers, counsellors or those with lived experience.

Despite the difficulties, stories were told about creative approaches to providing care out of necessity in country areas. 'One stop shops' have been established to provide integrated care for people in several locations. Many other locations were also seeking a one stop shop approach with "all services in one place" including general health, mental health, drug and alcohol, child and youth services, dentist and employment services. In some locations, one stop shops specific to the needs of youth and young adults were seen as important.

There are also particular population groups who have difficulty accessing services and for whom targeted approaches may need to be considered. Mainstream mental health services may not be culturally appropriate or sensitive to the needs of Aboriginal people, people from CALD communities, or LGBTIQ people. For people with complex mental health needs, access to services can also be difficult. Similarly, for people with specific mental health issues such as eating disorders, statewide services based at one location were described as difficult to access. Different approaches may be needed to advise various age and population groups about how to access appropriate mental health care and support.

***Many people reported that they cannot access or afford the primary mental health care services they need***

A key theme from South Australians via surveys, submissions and during conversations, was that ten Medicare-funded psychologist sessions per year was in many cases inadequate to address the need and establish a therapeutic relationship. Many South Australians told us that they could

not afford to pay private psychologist fees once the ten sessions had been consumed. As a consequence, they either stopped attending until the following year, thus placing themselves at risk of escalation of their mental health issues, or deliberately spaced the sessions out over the year which limited their effectiveness. Some South Australians indicated that where psychologists are charging a gap between the Medicare rebate and the fee charged; meeting the cost of even the first ten sessions was difficult, resulting in people deciding not to access professional help they may need.

South Australians also indicated that there are long waiting lists in the city as well as rural and remote locations to see private psychologists or psychiatrists, with access to adolescent psychiatrists being extremely difficult. Some South Australians told the Commission that these long waiting times often resulted in emergency department presentations either because the situation reached crisis or because they could see no other way of accessing help. Access was also limited in some cases because people could not afford the public transport costs to access services, or could not afford the service itself if they were ineligible for Medicare (e.g. international students).

### *There is growing support for sustainable services run by not-for-profit organisations, and recognition of community groups that provide lower intensity support and services aimed at hospital avoidance*

Many South Australians with lived experience, their families and carers, state-run mental health service providers and primary mental health care providers commented on the valuable role played by NGOs in supporting people experiencing or recovering from mental illness in the community. NGOs offer a variety of services and programs covering such areas as job readiness, relationships, living skills, social activities and recreational pursuits which can all assist with the psycho-social supports in a person's wellbeing, recovery and ability to live a meaningful life. Many people and NGOs told about the importance of employing and training a lived experience workforce to provide peer-based or peer-led support and to provide hope for people experiencing mental health issues.

Many South Australians stated that loneliness and isolation is a key driver to seeking support from services, and that this need may be better met not only by NGOs but also by other sustainable community models of support. This support is often provided by informal community groups such as faith groups, choirs, art groups, sporting groups and other communities of interest, but may also be provided by more formal community centres. For example, the Junction Community Centre at Mt Gambier has been established for over 30 years and provides a range of services, experiences and opportunities to support people experiencing mental health issues or recovering from mental ill-health. Members are encouraged to volunteer in taking an active role in the operation of the centre.

### *A range of options for support and care need to be offered to meet individual needs at different times, rather than a 'one-size-fits-all' approach; medication is important for many people, but equally so are a range of other options and interventions*

South Australians with a variety of lived experiences and also mental health service providers indicated that a range of funded or affordable options needs to be provided to support recovery. South Australian's experiences and needs are all different, and a 'one-size-fits-all' approach is too often applied but rarely appropriate. Whilst many people found medications invaluable to their recovery, with comments such as "it is only when the brain pain is alleviated [with psychiatric medication] that the soul can breathe a sigh of relief", others found that medication actually led to

more distress or was not helpful, particularly when forced. For some, a combination of medication and other interventions is most helpful.

In addition to talking or psychological therapies (e.g. cognitive behaviour therapy, dialectical behaviour therapy), South Australians also provided the Commission with examples of alternative psychosocial interventions or approaches they had found helpful to their recovery. These included peer-based support groups, non-clinical self-help resources, yarning groups in Aboriginal communities, art therapy, kinesiology, nature therapy, therapeutic communities, animal assisted therapies, Maastricht approach to hearing voices, and the Open Dialogue model.

## Summary of information heard during consultation with the Youth Advisory Group

*'It's either Headspace or the hospital: if there are other levels of mental health services then they're not widely known about or they don't exist.' 'The idea is no wrong door, but that isn't the case.'*

The Commission heard from members of the YAG that for services to be coordinated there must first be distinction and classification of services. Proper recognition would allow for greater understanding of available help, education and treatment that suits to individual needs and lifestyles.

YAG members suggested that many people have enquired about the possibility of a database or governing body that coordinates services and the information they provide to the public. This would allow stronger collaboration, direction, and purpose for both services and consumers. Services should consider a set of guidelines or a framework that outlines how services identify and understand people's needs, and how to provide appropriate recommendations for treatment.

## Summary of information heard during consultation with CALD community

*Accessing services for mental health can be a confusing and distressing experience.*

Members of the CALD community suggested that often there is a general lack of awareness and understanding about mental health literacy, and many feel at risk of stigma and discrimination when disclosing personal health information. This issue is compounded by the lack of resources that are culturally sensitive, and these concerns are even greater for people whose visa types are not covered by Medicare or Centrelink. Unless identified and treated, mental health issues can cause family relationships breakdown as well as increase a person's chances of being exposed to other issues such as homelessness, drug and alcohol and domestic violence.

The CALD community told the Commission that early intervention, as well as active social and physical participation in the community, is important to producing better outcomes. Assessment of mental health should be holistic, and include cultural sensitivity if needed. The minimisation of stigma, negativity, and discrimination through awareness and education programs can also have a major impact on the improvement of service delivery.

The CALD community also told the Commission that solutions are needed to address cultural and health literacy barriers. Health practitioners should have improved engagement skills to build cultural knowledge and better communication with their CALD clients. There should be greater use of languages other than English when providing information and services, such as prescribing medication. This can also be achieved through the effective use of interpreters and bilingual workforce; face-to-face communication and contact is preferable to information that is

written or translated. There is a push for less negative impacts when disclosing health information with regards to visas and employment.

For refugees and migrants in Australia, poor or non-existent social determinants, such as employment, education, and housing, can contribute to poor mental health. It is therefore necessary to empower communities to be able to provide relief in these areas. This could be achieved by building capacity within communities to indirectly contribute to the prevention of mental illness by providing education, programs, and services that cater to needs other than mental health.

## 1.2    Mental health promotion, prevention and early intervention

### Key findings from the 2017 SAMHC community consultation

**Work is being undertaken in homes and our communities to support infants and families, but more can be done in the early years; the Commission heard from a lot of people about the value and importance of early in life intervention**

Not only can poor maternal mental and physical health impact foetal development, the infant brain is then moulded during early childhood years by family relationships in a way that affects physical and mental health throughout life. Positive and secure attachment for the infant, and positive boundary setting and disciplinary approaches in early childhood, can influence a child's mental health.

The Commission heard from people in the community as well as clinicians and departments involved in early childhood work that there are some strong initiatives available or being implemented for vulnerable families. For example, Children's Centres in SA offer services focusing on children's learning and development within the context of their family and community. These centres aim to strengthen the capacity of families and the community to respond to children and provide the best possible start in life. Commission staff visited one of these centres and spoke to staff and parents who told of the importance of having a "soft entry" to provide support and assistance around parenting.

Antenatal services are also available in SA to provide information around pregnancy, birthing and parenting. Family services coordinators support vulnerable families and provide additional programs on parenting skills with a focus on relationships (e.g. Circle of Security program, Bringing Up Great Kids program).

However, many people the Commission spoke to and representatives of some government agencies sought a greater investment in developing parenting capacity and attachment in the first two years of a child's life. This included a call for greater availability of, and research around, parenting programs and their suitability for different groups. It was also noted that there is a lack of clarity regarding what 'parenting capacity' actually means.

*Greater community awareness and understanding of mental health and wellbeing has the potential to improve people's lives by reducing stigma and shame currently associated with mental ill-health, and by increasing people's willingness and ability to help others and seek help themselves*

Individuals, community groups, support groups and NGOs in both city and country locations advised the Commission that fear of stigma and shame stopped people being open about their struggles with mental health, and in many instances stopped them seeking help at all. This was either based on previous experience of negative repercussions at school, work or in other aspects of their lives, or based on fear of what may happen. In rural and remote areas in particular, many people expressed reluctance to seek help as they felt ashamed in a community where people had close ties or all knew each other.

South Australians not only felt shame about struggling with mental health issues, but also felt huge shame and difficulty in being open about traumatic experiences or other factors that may have contributed to mental ill-health. In some cases, disclosure regarding trauma experiences had led to a withdrawal of support due to eligibility criteria, professional competence or lack of knowledge on how to best support people. Traumatic experiences were reported to include childhood abuse or neglect, domestic violence, or major life crises, but it was also clear that the definition of 'trauma' in this context was ill-defined and inconsistently understood.

People with trans or other gender diverse identities advised that experiences of stigma and discrimination in relation to their gender identity had also impacted negatively on their mental health and had led to difficulty being open or accessing services. This can be particularly difficult for people of CALD background where their sexual and cultural identities may clash to coexist; many spoke about the double life that they live in order to address the stigma and discrimination experienced within their own ethnic communities because of their sexual and gender identity as well as within the LGBTIQ mainstream community because of their ethnicity. Many South Australians called for not only broad community education around mental health and mental illness, but also around trauma and diversity.

It was acknowledged that campaigns to reduce stigma associated with depression and anxiety had raised community awareness, understanding and willingness to seek help. However, there was still considerable stigma and lack of community understanding associated with other mental illnesses including, but not limited to, schizophrenia, borderline personality disorder, and people in general who experience psychoses. Young people advised that television shows and social media with the message "mental ill-health is part of life and nothing to be ashamed of" were helpful as they normalised mental illness and reduced associated stigma. However, they also advised that this is a tricky area and messages are not always helpful.

Parents, young people, community members, teachers, allied health workers and other workforces talked about the usefulness of training in 'mental health first aid', similar to physical health first aid. People advocated for this training to be available and widespread and they called for it to made available to those working in health services, first line responders, teachers and support staff, school students, university staff and students, pharmacy staff, GP staff, prison officers, welfare service staff and the community more broadly. Many South Australians stated that any mental health first aid training or community awareness campaign needs to be mindful of language used and message delivery. For example, education may need to espouse the diversity of normality alongside mental health literacy and the need for 'intervention' or support. It may also

need to include how to provide trauma informed 'first responder' support, and ensure that it is not teaching people how to be 'mini-diagnosticians' as this could potentially cause harm.

Community education may also need to be tailored to parents from CALD backgrounds and could offer 'toolkits' of practical steps for supporting oneself or others around mental health or suicide prevention.

Many people told the Commission that while GPs are well placed to act in a primary care role, they often do not have the time or understanding to recognise or explore the background trauma or other issues that may be contributing to people's mental ill-health. People in many rural areas told the Commission of the difficulty accessing timely appointments with GPs and many spoke of the expense associated with accessing these and other health services. Numerous stories were told of where medication had been automatically prescribed with inadequate, or no, exploration of contributing factors, and where the person had not contributed to their own 'management plan'. Conversely, a number of individuals felt that there was a stigma around use of psychiatric medications, which for them had been incredibly helpful. Intervention in a 'crisis situation' likewise may need to look quite different from pre-crisis or post-crisis intervention.

South Australians told us that "if things were working well, we would not need an 'Are you ok?' day" as mental health would be part of everyday conversations. South Australians would no longer feel that seeking help may be perceived as a sign of weakness, but rather be seen as taking an active role in managing their own mental health.

### *Summary of information heard during consultation with the Youth Advisory Group*

***Resources, strategies, and programs need to be better identified and more appropriately targeted. Different frameworks and opportunities could be utilised by governments.***

YAG members told the Commission that service providers should utilise lived experience in prevention and intervention strategies. Many young South Australians want to see less discrimination and stigma when discussing mental illness and suicide. As an example, Batyr Australia trains young people with lived experience to speak about their mental health journey at schools and universities. This is to 'smash the stigma' around mental illness, and raise awareness about mental health and self-care strategies and approaches. This approach is effective because individuals with lived experience can see their mental health in a positive light and feel that they are able to progress forward.[i]

Effective health promotion is often seen as education programs in schools, in addition to indirect forms that target the problem without explicitly stating so. This includes community-based projects, which can be diverse in nature, such as social groups or gardening gatherings. Targeted mental health promotions found on social media have had short term effectiveness, though they are able to reach a wide audience with ease. There is a need for understanding of what constitutes a mental health promotion activity, and how communities can be greater involved in them.

Young people involved in consultations suggested that providers should introduce more psychosocial strategies into intervention for affected individuals. All GP clinics and medical

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[i] Batyr Australia, < https://www.batyr.com.au/>.

centres should have a mental health worker who has specialist mental health training beyond that of other practitioners. There is also a need for non-suicide focused early intervention and prevention programs that are better funded and planned. Incorporation of postvention, in addition to prevention and intervention, is missing and needed. There is a need to follow up with individuals who have successfully responded to treatment and therapy to avoid relapse. Hospitals need more specialised resources and funding to deal specifically with mental health crises and emergencies. This needs to be linked into coordination with community services as well.

## 1.3   Suicide prevention

### *Summary of information heard during consultation with the Youth Advisory Group*

**Research should be conducted into why suicide prevention programs are not stopping the rising rate of suicides.**

Members of the YAG stated that in addition to the need for suicide prevention, there is a need for more prevention of the factors that lead to suicidality.

Traditionally, outcome assessment has focused on clinical outcomes such as symptomatology, social disability and service use (i.e. admission rates). However, there is an emerging consensus that this is not appropriate for the current mental health model in use.

YAG members told the Commission that mental health services in Australia should operate with a recovery focus. Recovery has previously been defined by Anthony (via Thornicroft & Slade) as '… a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles' and 'a way of living a satisfying, hopeful and contributing life even with the limitations caused by mental ill-health.'[ii]

The challenge then is how to measure recovery in a way that is both logical and meaningful. One method that is gaining traction is the use of the 'CHIME' framework. Identified through a systematic review, this framework identifies five recovery processes: Connectedness (social inclusion, community integration), hope and optimism, developing of a positive identity, meaningfulness in life, and empowerment.[iii]

If the goal of a mental health system is to facilitate recovery, then mental health workers need to know how to work in a recovery oriented way and be able to demonstrate measurable outcomes. . New evaluation measures and tools involving a recovery approach are becoming more readily available, such as the Maryland Assessment of Recovery in People with Serious Mental Illness. This uses a 25-item self-report instrument designed to assess recovery status in people with serious mental illness.[iv]

Evaluation approaches and measures need to be restructured to look into progress and success of prevention, intervention and postvention strategies.

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[ii] *Thornicroft, G & Slade, M 2014 'New trends in assessing the outcomes of mental health interventions', <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4102275/>.*

[iii] *Leamy, M et al. 2011 'Conceptual framework for personal recovery in mental health: systematic review and narrative syntheses', <https://www.ncbi.nlm.nih.gov/pubmed/22130746>.*

[iv] *Bellack, AS & Drapalski, A 2012 'Issues and developments on the consumer recovery construct'.*

## 1.4    Comorbidities

### Key findings from the 2017 SAMHC community consultation

**There is a call for greater integration between health and mental health services to reflect the relationship between physical health, mental health, and drug and alcohol misuse**

Numerous stories were told of South Australians who had been turned away from mental health services because they had a substance abuse problem, or turned away from Drug and Alcohol Services SA (DASSA) services because they had a mental health issue. These stories came from individuals, their families and carers, service providers within Mental Health Services or DASSA, professional groups and other organisations who had sought input from their communities. Similar issues were raised in both metropolitan and country areas, and in a variety of settings. Mental health clinical service providers stated that part of the reason for this is that many staff feel inadequately trained to manage people presenting with alcohol and other drug related psychoses/ other mental health concerns. Some people were calling for greater integration of mental health and drug and alcohol services, whilst others felt that there should be a separate pathway established for people presenting with drug-induced psychosis or drug and alcohol related mental illness. Suggestions included accessible crisis centres, detoxification beds and rehabilitation centres.

In addition, the CALD communities in SA spoke also about the link between isolation, trauma, lack of adjustment to Australian culture and addiction including drug and alcohol and gambling problems.

South Australians also advised that there needs to be greater recognition of the interplay between physical and mental health. People are concerned that there are insufficient mental health services for those with physical health problems, and also that there is insufficient focus on the physical health of people with mental health problems. The Commission was provided with references and research indicating that effective mental health care in conjunction with quality physical health care can improve quality of life and outcomes for consumers, and also reduce pressure on the health system. South Australians were deeply concerned about the evidence demonstrating that on average people with a significant mental illness experience a life which spans 20 years less than people who don't have a mental illness.

## 1.5    Health workforce and informal carers

### Key findings from the 2017 SAMHC community consultation

**Alternative workforce models, including expanded peer workforce roles and peer led services, may assist in providing timely and appropriate access to care and support**

The Commission heard strongly from the NGO sector, people with lived experience and also from some mental health services, about the value of peer support, peer workforces and/or peer led services. As well as playing a key role in the NGO sector, suggestions and examples were made of other roles where peer workers could potentially play a valuable part. These included delivery of targeted or widespread mental health first aid training, peer-led crisis respite centres, provision of peer based support services particularly in country areas, and potential roles within emergency departments, sub-acute services and with SA Police or other first responder organisations. South Australians are seeking a systematic and planned approach to a professionalised peer workforce

or peer led models to ensure consistency in access, support and accredited qualification for this workforce across services.

With respect to provision of emergency response services, it was suggested that mental health workers may play a valuable role assessing need and avoiding presentation to emergency departments where possible.

Pharmacists suggested that their role in mental health could be built on as they are often the health professional to see people most often with mental illness when they collect their medication and they are also widely spread across SA, sometimes the only health professional in town.

Trained counsellors indicated that they may also have a valuable role to play in provision of non-crisis support or intervention for people at risk of or with mild to moderate mental illness. However, counsellors also stated that there was substantial variability in qualifications and training of persons who called themselves counsellors, and some felt that a minimum qualification/certification or accredited standard of training may need to be specified.

***Families and carers of people experiencing mental illness often feel inadequately supported or excluded from decisions, despite playing a key role in the provision of ongoing care and support in many cases***

Families and carers of South Australians experiencing mental ill-health told the Commission that they often felt inadequately supported and often excluded from decisions regarding the person's care, despite the person's permission to be included and/or where they play a key role in provision of ongoing support. Agencies working with people with severe and complex mental illness or needs reinforced that families and carers often play a key role and should be actively included and consulted in care processes wherever possible.

Carers often get little relief or support which makes employment and social engagement difficult. Children of parents or siblings with mental ill-health may also play a caring role, and if unsupported may be vulnerable to developing mental health issues themselves.

The Commission heard that carer consultants can play a key role in supporting families and friends to understand ways to support the person with mental health issues, how to manage their own mental health and wellbeing, and how to access other supports available to them.

South Australians recognised that there may be issues around confidentiality and information sharing when involving families and carers in decision making, but felt that these issues should be acknowledged and solutions sought to allow appropriate involvement wherever possible. Comment was made that knowledge sharing and relationship building by practitioners with families and carers can occur in many circumstances without breaching privacy.

***Systems, staff and volunteers working with or responding to people with mental health issues, particularly those who work outside mental health services, may not always have sufficient training or understanding in the areas of mental health, trauma, crisis, recovery and/or person-centred care to allow them to be able to respond skilfully and compassionately to people experiencing distress***

South Australians told the Commission that a broad community awareness campaign as well as targeted training for specific workforces, would not only improve community understanding and reduce stigma associated with mental ill-health, but also improve the ability of workforces to respond skilfully and compassionately to people experiencing mental distress.

A coordinated, consistent and systematic approach to staff training would ensure ongoing professional development in new evidence-based practice or models of care. Staff of mental health services and South Australians with lived experience suggested that additional training for mental health staff could include trauma-informed practice, approaches for management of or intervention for substance misuse, and education to increase awareness and sensitivity to the needs of particular population groups such as Aboriginal people, people from CALD backgrounds, and Gender and Sexually Diverse persons. Training for mental health service staff should also include non-clinical staff and volunteers, who often play a key role in service delivery and interact widely with service users. Alongside a need for specialised training, we also heard that "mental health workers need great support to deal with the hard and wonderful work that they do".

Other clinicians not directly employed in specialised mental health services but with responsibility for assisting people with mental health issues may also benefit from additional and ongoing training opportunities in mental health and related areas. These clinicians particularly include GPs and staff working in emergency departments. Specific areas where training may be useful included mental health and mental ill-health in general, working with people who are suicidal, trauma informed practice, approaches for management of or intervention for substance misuse, psychoses and voice hearing, management of serious and complex mental illness or people with mental illness and other comorbidities, and education to increase awareness and sensitivity to the needs of particular population groups. The aim of additional training may not only be to improve skills, but also to improve awareness and understanding of when and where to refer people for more specialised support when required.

Training in mental health and related areas may improve the ability of other workers in areas where they are assisting people experiencing mental health issues to respond more skilfully and compassionately. These areas include those working in general health services, first line responders, teachers and support staff, university staff, pharmacy and GP practice staff, prison officers, welfare service staff and the community more broadly.

## 1.6    Housing and homelessness

### Key findings from the 2017 SAMHC community consultation

**Social determinants such as being able to access safe secure housing continue to substantially impact prevention and recovery outcomes**

The need for secure and appropriate housing was raised many times as a key factor in not only helping to prevent the onset or worsening of mental health problems, but also as a key barrier to timely discharge from hospital for many people. Several service providers in both city and country locations called for a greater number of mental health supported accommodation packages such as those available through the Housing and Accommodation Support Partnership (HASP) Program. A need for a variety of supported accommodation ranging from 24/7 support to less supported is required in metropolitan and country SA. It was also noted that in general housing options may not always be appropriate for some people who experience chronic conditions and complex circumstances. For people with complex needs, alternative housing options and models need to be considered.

South Australians commented on the need for "villages" where people can support each other and feel connected. However, there was some disagreement as to what these villages should

look like. Some felt that supported housing options should not create clusters of people with mental health issues, whilst others felt that this would be the best model to provide more immediate peer as well as staff and service support.

There was a call for more community and supported housing, "not just dodgy hostels with tiny bedsit rooms." It was also raised that people residing in boarding and rooming houses are no longer considered homeless and that some welfare supports may cease as a result. Also, due to the often episodic nature of mental illness, people hospitalised for acute care risk loss of housing or job because they have been unable to pay their rent or attend work. This further exacerbates stress and impacts people's mental health. There is a call for more support to ensure that eviction or loss of job does not occur in these circumstances.

## *Summary of information heard during consultation with CALD community*

*Safe, accessible housing is a human right, as well as being fundamental to a healthy, well-functioning society. Private and public housing should both have a strong community focus.*

Attendees at the CALD community forum noted many barriers and concerns regarding housing for people within the multicultural community who experience mental health issues. The community highlighted a strong desire for increased housing stability and greater certainty when accessing housing.

The Commission heard that CALD communities strongly believe that long waiting lists and procedures for access to public housing contribute to higher level of stress and anxiety. The Commission also heard that it is getting harder to find affordable and accessible private housing, especially for larger families. There are many costs involved with finding and maintaining appropriate housing.

For people to be able to meet these costs and have home ownership, they require steady employment that provides adequate pay. This is a particular challenge for people from a multicultural background and especially for parents who have arrived in Australia as refugees and have the responsibility to support their family members. Another specific example of this is the challenge faced by international students, who risk losing the focus of their studies when they are required to work to meet the high costs of housing. This may contribute to increased mental ill health and stress related disorders.

The CALD community suggested that there is a need for greater support of multicultural families to increase their financial literacy and understanding of the systems that influence housing. Concerns were also expressed about the accessibility of bank policies and procedures in relation to private housing. These were recognised as being overwhelming processes that can contribute to stress and anxiety. It was suggested that public housing authorities should be equipped with a cultural consultation team to better understand the needs and wants of the multicultural community.

The CALD community expressed a desire for different models of housing that better reflect a connected community. This includes models that 'spread out instead of building high', and that provide more communal spaces such as community gardens. Examples of this are drawn from Sweden, where housing allows for people to be brought together whilst living independently.

There were also suggestions for peer education, as well as programs and models that promote connectedness between neighbours and communities. It was suggested that these programs should be led by public housing authorities.

## 1.7    Income support and social services

### *Key findings from the 2017 SAMHC community consultation*

**Social determinants such as being able to access a regular income continue to substantially impact prevention and recovery outcomes**

Accessing welfare support via Centrelink was reported by several individuals to be "traumatising and shaming". The Commission also heard that people with mental health issues can experience discrimination and difficulty accessing health insurance coverage and making claims. Financial stress can significantly impact people's mental health, and the Commission heard from South Australians with mental ill-health, homeless youth, and people in rural and remote areas who all reported that navigating the welfare system and dealing with staff who are sometimes not as helpful as they could be, can all lead to additional mental distress. While the ability to participate in meaningful work, education or volunteering opportunities was helpful for many South Australians, for others full time paid employment may actually not be a realistic option. Pathways to employment for people recovering from mental ill-health also need to actually provide incentive for people to work.

South Australians felt that front line welfare support staff, as well as staff in many other organisations including first line or emergency responders, teachers and corrections, would benefit from education or training in mental health and particularly in trauma-informed care to improve their awareness, understanding and skill in responding to people's vulnerabilities and the often social context to their situations.

## 1.8    Facilitating social participation and inclusion

### *Key findings from the 2017 SAMHC community consultation*

**Loneliness and isolation are widespread and people are crying out for a sense of community connectedness and wellbeing**

The Commission heard from people of all ages and all walks of life that feelings of loneliness and isolation are key problems in the community which can lead to or greatly increase people's mental distress.

Older people identified that whilst being supported in their own homes could be a good thing, often loneliness was a big issue when physical health problems impacted their ability to interact with friends. Young people identified that leaving school was a particularly difficult time as they lost connection with their school community. Other young people said that life without friends was very depressing. South Australians experiencing mental ill-health advised that loneliness and disconnection were doing them harm and leading to negative impacts on their mental health. South Australians who had experienced psychosis stated that they "put up with processes like diagnosis or forced medication when the need for human connection became so urgent that the trade-off and risks seemed worthwhile."

The Commission heard from people in the community who had lived in the same house for three years but never met their neighbours. There was a strong message from South Australians lamenting the loss of local community, the 'village square', and the ability for 'villages to raise our kids'. In some country areas, there was a sense of hopelessness which had pervaded the community. Aboriginal communities advised how essential it is to have safe places or spaces where the community can gather to support and teach one another.

The Commission also heard some examples of where communities or councils had developed their own 'grass roots' wellbeing initiatives. Mentally Fit Eyre Peninsula is a program created by local people for local people to empower the community with understanding and tools for mental health and wellbeing. Supported by a local committee and the local community, with generous donations from local businesses and money raised through local functions, they fund qualified counsellors to provide information sessions and counselling to help reduce stigma around mental ill-health and to increase help seeking behaviour.

Mt Gambier Council have embedded mental health into their strategic plan, and are using local networks to build community activities focussed on wellbeing, including for people with varying degrees of mental ill-health who are otherwise disconnected. However, there were other councils who felt that even if they had funds available they would be unsure how to progress mental health or wellbeing initiatives in their communities, or what their responsibilities were in this regard. In Lameroo the community spoke of being far away from mental health services and having to help themselves. They mentioned the Friday night men's group which helped to check on and support men within the rural community, but they also told us that their community needed more support.

The Commission heard that opportunities for community connectedness also helped people to find something meaningful to do and to take more responsibility for helping others and themselves – "not just about the me, me, me". Many examples were provided of how this was occurring in both city and country locations, including local sporting clubs, churches, volunteering, art groups, choirs, blacksmith groups, and poetry groups. South Australians felt that "the way we plan our suburbs is critical to improving mental health outcomes", and such plans may include community hubs, suitable public transport and green spaces to build stronger connections in the community.

Some South Australians with mental ill-health advised that they were looking for connection and friendships with people who were not mentally ill "so we don't make each other more mentally ill". Others were seeking connection with others who "spoke a common language so we can all be crazy together." Creating the spaces for people to connect and make friendships with people of their choice was seen as critical.

Alongside the need to rebuild a sense of community connectedness, many South Australians felt that there was a need to build a sense of wellbeing at both an individual level, but also at a community and population level. It was acknowledged that 'wellbeing' is hard to define, but is likely to be more than addressing the known social determinants of mental health and wellbeing such as housing, health, good relationships and employment. The SAHMRI Wellbeing and Resilience Centre is progressing work at a community level in this regard, focussed on the work of Seligman around positive psychology. Several other tools for promotion of mental wellbeing also exist, including 'Five Ways to Wellbeing' which has been adapted for use overseas and local use in other parts of Australia.

The role of nature in helping promote wellbeing, prevent mental illness and also facilitate recovery was highlighted by a number of people and organisations. A sense of meaning, purpose, and a reason to get up and go out was also highlighted as important to providing a sense of wellbeing, including for those who have experienced trauma and suffering.

## *Summary of information heard during consultation with the Youth Advisory Group*

### *There are many different population sub-groups that may feel socially isolated and there should be greater accessibility to services for people in these sub-groups*

YAG members told the Commission how non-government organisations provide psychoeducation support and treatment for many Australians, especially young people. They commented that it is often easier and less threatening to access non-government services than government services. Non-government organisations should continue to be funded to provide these important community-based programs.

Inadequacies within social participation and inclusion can result from excessive negative connotations associated with the mental wellbeing of the multicultural community, people who identify as gender and sexually diverse, and people with physical, intellectual, and learning disabilities. People in these sub groups are often at risk of social exclusion and are likely to 'fall through the cracks' when attempting to access services. While this is an area that is improving, there are still many barriers for people in these sub-groups, especially in an education setting. Other socially isolated sub-groups include offenders and those in the corrections system, people who live in rural and remote areas or come from a lower socio-economic status, and people who are isolated due to homelessness or substance misuse.

YAG members stated that services need to be more accessible for people in the identified sub-groups, such as safe spaces, drop in centres, and youth centres that target 12-18 year olds specifically. These services should provide specialised inclusion programs and help to improve mental health literacy of the community, in addition to reducing stigma and discrimination surrounding mental ill health. There should be increased utilisation of peer support workers, including youth peer workers within mental health services.

The utilisation of the 'social return on investment' approach to understand and manage the intangible impacts of a mental health project may work as an appropriate starting point for governments. Within the social return on investment framework, the views of impacts of all stakeholders' are accounted for, and 'financial value' is put on impacts that do not typically have a dollar value.[v]

## *Summary of information heard during consultation with CALD community*

### *Inclusion and active participation in the community is an important part of wellbeing for many families. This has even greater meaning for people who experience mental ill health, as it helps to maintain a sense of purpose and connectedness.*

There was a common theme from the CALD community that with support, communities can utilise more formal and informal social events, particularly those that are cultural or sporting.

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[v] Social Ventures Australia Consulting 2012, 'Social Return on Investment: Lessons learned in Australia', <https://socialventures.com.au/assets/SROI-Lessons-learned-in-Australia.pdf>.

These types of events promote intercommunity connectedness, as well as active and healthy participation in life and wellbeing. These events can also act as an opportunity for services to communicate to the community about the services available for people to access for assistance.

Elders and leaders within communities work well as points of contact with regard to mental health issues and other personal issues. Other means of access include religious and community centres, technology-based services, and services that employs the concept of a 'one stop shop'. These access points may help to avoid the issue of service integration breakdown, as well as improve service use and reliance on technology, particularly for young people. It should be noted that for these services to be successful, culturally appropriate language and information are essential.

The Commission heard that community and social identity extends beyond the neighbourhood into many aspects of life. This is in parallel to the way mental wellbeing affects all of life's facets. Many South Australians would like to see improved mental wellbeing at a whole-of-people and whole-of-community level. They hope for decreased unemployment rates and improved diverse employment opportunities that provide families with good quality of life. The community wants to see mental health literacy improved through higher literacy rates, better cultural education in school and English language programs. Most predominantly, the Commission heard from the South Australians engaged in this consultation that they want to see stigma around mental health issues become a thing of the past.

Communities should be able to contribute positively to the wellbeing of those who may struggle with mental ill health. Funding should be made available for community needs that sustain community connectedness; with the development and implementation of a database that is transparent to all communities.

## 1.9    Justice system

### Key findings from the 2017 SAMHC community consultation

**The Commission heard that South Australians in prison had limited or inadequate access to mental health services and supports.**

Despite a high rate of mental health issues, it was indicated that access to a psychiatrist in prison was "virtually zero" unless the person was under a forensic psychiatrist – "ten minutes with a psychiatrist every six months does not help". Greater access to social workers and potentially to peer workers is likely to be beneficial, but resources are limited and provision of in-reach services was difficult due to lack of resources for supervision. South Australians told us that rehabilitation is focussed on training and employment rather than on mental health and wellbeing post release, and that greater access to mental health supports and services leading up to and following release may reduce recidivism. It was suggested that this could include notifying and linking in with community mental health teams to begin contact with about-to-be released prisoners. OARS Community Transitions work with social workers, prison officers and Prison Health to help with prisoner transition back into communities, but do not have the resources to work with every prisoner on their release. In addition to greater access to clinical support, the Commission heard that additional training for prison officers in mental health and trauma informed practice may be helpful to increase understanding and provision of support for mental health needs of prisoners.

The Commission heard that the provision of mental health care for forensic clients is intensive at the point of admission but not at the point of discharge. For forensic clients with cognitive impairments, there is a need for specialist services which can also provide appropriate housing and support on release.

## *Summary of information heard during consultation with the Youth Advisory Group*

### *The mental wellbeing of victims, especially women and children, is often overlooked when having to interact with the legal system.*

Australia's legal system relies on the concept of 'innocent until proven guilty'. This requires victims, who may be experiencing distress as a consequence of crime perpetuated against them, to 'prove' themselves to the court. There may be little to no understanding of the impact on victims' mental health.

Ignoring mental ill health is even more damaging. Going to court may involve stressful, debilitating, and unjust processes that directly and negatively impacts mental wellbeing. These practices often leave people with mental health issues in worse condition than before they came into contact with the system.

We heard from the YAG that whilst consideration is given to the mental state of offenders, this generalises and assumes that all offenders are individuals who have gone through rough times and are in need of support. The same consideration for victims can be limited.

Many Australians who come into direct contact with the legal system have low socio-economic status. There needs to be more options for people struggling with socio-economic hardship to be adequately able to represent and defend themselves. This is exacerbated further when the individual is impacted by mental ill health.

Some of the members of the group spoke of experiences victims of crime had and felt that more consideration and support needs to be given to victims of crime, rather than the focus being solely on offenders.

People participating in these consultations spoke of popular forms of rehabilitation programs related to animals being useful. Research into programs such as equine assisted therapy in the United States show the direct link to improving prisoners' mental wellbeing, as well as the percentile reduction of reoffending.[vi]

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[vi] Bachi, K 2014, 'An Equine-Facilitated Prison-Based Program: Human-Horse Relations And Effects On Inmate Emotions And Behaviors', City University of New York, <https://academicworks.cuny.edu/cgi/viewcontent.cgi?article=1161&context=gc_etds>.

## 1.10  Child safety

*Key findings from the 2017 SAMHC community consultation*

***Several clinician groups and service providers indicated that a focus on early-in-life intervention, particularly for at-risk children and families, had demonstrated success not only in individual outcomes but also in reducing future government expenditure.***

Clinicians and service providers suggested that early-in-life services focused the perinatal and postnatal journey should involve infants from birth (or even pre-birth) and their parents up to age two or three. Many were disappointed at the discontinuation of the National Perinatal Depression Initiative in 2013. Most important was the reported "need for greater integration" between perinatal services, CaFHS, CAMHS and DECD funded Children's Centres, with relevant shared training in provision of parenting support and to identify and appropriately manage children at risk of developing or who are exhibiting mental ill-health. These services should also be linked into services for middle childhood, adolescence and adulthood. Some clinicians felt that there was currently a gap in services available in SA for this infant age group, despite antenatal identification of families at risk. Child and Family Assessment and Referral Networks (CFARNs) provide targeted intervention for families of children from before birth to two years of age, who are identified as at-risk under the child protection system.

CAMHS is often involved with at-risk children, many of whom have experienced trauma or adversity in early years. However, the resources often get prioritised to emergency and acute interventions rather than early-in-life prevention, and that additional resourcing or service integration may assist in offering greater support to mothers and children who have experienced or are experiencing trauma, domestic violence, drug and alcohol issues, mental ill-health.

The Commission heard that there are instances where mothers and infants may be identified as high risk due to trauma, domestic violence, drug and alcohol issues, but that due to inadequate resources, early-in-life preventative or intervention services may not be available for these families until there is a crisis. A clear issue was also how the needs of both the infant and the mother, father or family can be met and by whom, including whether continuity-of-support-provider was possible from antenatal to postnatal services particularly for vulnerable families where this transition period may be difficult.

The Commission heard that early-in-life intervention should commence antenatally through to two to three years, and should involve promotion, prevention and early intervention initiatives. The loss of the National Perinatal Depression Initiative was highlighted as leaving a gap in ability for services to provide screening and early intervention, despite the need still being there.

For children brought up in out-of-home care including those under the Guardianship of the Minister, the transition to 'adulthood' can be extremely distressing and traumatic. Many of these children have already experienced significant trauma or hardship in their lives, then at age 18 are no longer eligible for ongoing out-of-home care. Not only are they expected to be able to live independently from their 18th birthday, but "the mental health care system they previously relied on won't accept them anymore and they are forced to navigate an adult system not set up for their types of issues". NGOs working with these children and young adults are seeking an ability to support the carer connection beyond 18 years, and/or formally allocate other care providers or mentors to assist them and act as role models (e.g. adults who have also previously experienced out-of-home care). Help may include accessing services, employment or further study. Some of these children in out-of-home care also have physical or intellectual difficulties as well as mental

health issues, and without appropriate support often end up socially isolated or in prison after leaving care. It was reported that some young adults thought that prison was a good outcome though, as "they are fed, have something to do and a reasonably safe place to sleep."

## Summary of information heard during consultation with the Youth Advisory Group

**We heard that stigma about mental illness surrounds single parents, particularly mothers, which makes the acknowledgement of mental ill health and the accessing of help harder to achieve.**

YAG members gave examples of the severe negative effects of stigma on children's mental health and wellbeing. There is an urgent need for improvements to the treatment of single parents and carers within the system. There is also a need for improved access to support the mental health and wellbeing of children.

Mental wellbeing and mental illness are both closely linked to child safety and development. Improving the understanding of how mental illness may act as a potential risk factor in individual child protection cases can help the system improve its support and education of affected parents and families. Renewed research efforts should also play an important role in the future of Australia's child protection services. The system should develop its understanding of contextual factors and their treatment (substance abuse, etc.), the perspective held by various stakeholders, and the impact of community-based treatment. This will allow the system to improve the treatment of mental health within the context of child safety, as well as ensure it is holistic for the whole-of-person, whole-of-family, and whole-of-community.

## Summary of information heard during consultation with CALD community

**Child safety and protection are important for healthy development and care of young Australians. The child protection system needs a stronger focus on culture and community to achieve positive outcomes.**

The National Framework for Protecting Australia's Children 2009-2020 outlines six supporting outcomes to achieve high level success through focussed efforts and actions. Within this framework, the importance of culture and community, especially for indigenous Australian children, is highlighted as a key outcome.[vii]

Within the community consulted however, there is a belief that Australia's child protection system is culturally incompetent. The use of western ideas, testing, and assessment leave many members of the multicultural community at a disadvantage when interacting with the system. The system fails to consider that child safety and mental health are viewed differently depending on the setting and cultural background.

There is a general feeling in the CALD community that the workforce within the mental health system lacks multicultural representation, as well as there being a lack of available funding and other resources for many in the community. This has led to an imbalance of power, with many members of the workforce feeling overworked and at odds with their position within their own communities. The child protection system requires a workforce and legislation which is not based

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[vii] Council of Australian Governments 2009, 'National Framework for Protecting Australia's Children 2009–2020', <https://www.dss.gov.au/sites/default/files/documents/child_protection_framework.pdf>.

solely on western culture, and better multicultural teams within leadership and clinical supervision roles. This provides cultural perspective and safety within the system for the families concerned.

Members of the multicultural community told the Commission they struggle to understand and navigate the system, due to lack of relationships and trust between staff and CALD communities as well as due to lack of culturally appropriate information. This is further frustrated by lack of integration between mental health services, the community, and the child protection system. There are also deficiencies within intensive case management and settlement services.

Improvements over the years in the education system, such as the implementation of psychologists and counsellors in schools, have increased the capability of the education system to identify potential issues earlier. More child centred services and programs should be utilised however, to provide spaces for families to develop skills and knowledge, in particular to help people understand parenting with the context of Australian culture. Consumer informed models, peer work that is driven by children's voices and experiences, and support systems for parents to deal with cross cultural conflict within families are all examples of services that could provide a voice for children and families and allow them to build control and resilience.

There is a desire from the communities consulted for more consideration to be given to culture and gender, along with greater cultural competence within the system and workforce. Culture should be seen as a protective factor in the child protection setting, rather than as a drawback. There is a need for an increase in alternative health options that are culturally informed, and that include the use of ethnic languages, more accessible resources and family networks.

## 1.11   Education and training

### Key findings from the 2017 SAMHC community consultation

**In schools and universities there is work happening to build wellbeing and resilience, but there is a need for a coordinated approach that meets the needs of all children and young people, and a call for qualified counsellors to be available in all South Australian schools**

Half of all common mental illnesses arise by the age of 14, and three-quarters by the age of 24. Recent research is showing that one or more adverse childhood experiences can be important predictors of adult physical and mental health . Adverse childhood experiences include abusive or neglectful parenting, domestic violence, parental substance abuse, and divorce or bereavement in the family. The parent-child relationship, parenting more broadly, and a positive school environment can all impact future mental health and wellbeing.

In the course of consultations the Commission heard about a number of different programs being conducted in the State's public and private, primary and secondary schools focussed on building mental wellbeing and resilience in young South Australians. The statement well-made was that by investing in these programs, "we are growing a generation with a much more heightened awareness of their abilities to manage their health and wellbeing." Examples of programs include training in mindfulness and positive psychology, and specific programs such as Kidsmatter and Mindmatters. However, there was a clear call for a state-wide, consistent and systematic program to be implemented for building and supporting wellbeing and resilience in school-aged children. This goes beyond the various tools being used to measure wellbeing in schools. It would involve an agreed and coordinated approach to wellbeing and resilience measurement, training and

implementation, with ongoing support. It would need to ensure that it also reached children and young people who are not attending school or who are enrolled in flexible learning options.

Any programs to build and support mental health and resilience in school-aged children may also require education for teachers and other support staff on how to recognise children for whom general wellbeing and resilience training may not be appropriate at that time, and have programs in place for supporting these children. This may include children and young people who have already experienced, or who are experiencing, significant trauma. These children may need help to effectively manage relationships, including relationships with services, before resilience training is even considered.

There was a strong request from many young South Australians, as well as youth support services and other NGOs, for trained, qualified counsellors to be available or employed in all schools. The need for trained counsellors/psychologists, rather than teachers nominated to a counselling or wellbeing educator role, was identified in many conversations and also in submissions and survey responses.

Additional support may be required in our schools and universities for young people who are part of groups who are particularly vulnerable to developing mental health problems. These groups include people who identify as lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ); who are from Aboriginal or CALD backgrounds; those experiencing learning disabilities; young people from poor socioeconomic backgrounds; young people in out-of-home care or young people who enter the criminal justice system.

## Summary of information heard during consultation with the Youth Advisory Group

### There are several factors that can hinder the success of students experiencing mental ill health.

Many schools now attempt to have easily accessible counsellors, psychologists and student wellbeing officers. However, YAG members explained how different institutions may have different criteria for how and when students can access these services, the quality of these criteria varies significantly across schools and disparity exists across the quality of care provided by schools. An inadequacy in education and training of staff and students, alongside lack of specialised support, leaves many teachers undertrained and struggling to provide care.

YAG members told the Commission about how across Australia, there is also disheartening stigma and discrimination attached with accessing mental health services within schools. Students often feel pressured to avoid seeking help as casual derogative use of mental health terms is widespread, particularly on social media. Students may wish to hide their mental illness out of fear of bullying and harassment, or because they are unsure how school based treatment can assist mental illness born out of non-school based factors. These factors lead to other concerning issues such as truancy, dropout rates, and adolescent substance abuse.

The young people consulted suggested that consideration should be given to how governments can provide specific funding and continue to work closely with service providers, schools, families, and communities to consider the best ways to provide adequate mental health support and education within schools. Schools should also consider services that do not directly treat mental ill health, but rather help to lessen the stress of other factors. Examples of this include proper education on substance misuse, and accessible spaces within the school to provide students with a safe space to relax and informally chat about their daily lives.

***Disparities in service accessibility, discrimination and stigma, and lack of mental health literacy are affecting the success of school and university aged students. In-school solutions to these issues have been recognised as effective, and are wanted and needed.***

Succeeding in school and university can be a challenge for any student, but for those experiencing mental ill health, there are many more disadvantages. Strong cultural beliefs especially around seeking help, judgemental behaviour, stigma around mental illness, trust and competency issues, and lack of mental health literacy can all affect a young person's abilities in the classroom environment.

The Commission heard some schools are often not equipped to deal with students with mental health issues. For those schools that are equipped, sometimes these resources are confusing, limited in scope, and lack continuity between schools, different levels of education, and the wider community. There should be greater sharing of information between institutions and the community, allowing parents and schools to have more knowledge about mental health and shared pathways to support their children. People with networks within the broader communities should be elected as representatives who can speak within their community and act as a point of contact between institutions. Regular mental health check-ups from primary to tertiary level of education could be considered. This may help to improve the rate of early intervention and allow students more understanding and awareness of mental health as a key factor of their overall wellbeing.

Within schools and universities, some of the people the Commission heard from suggested that some students with mental health issues would benefit from less standardised means of performance review and more positive reflection upon their work and progress. In the short term, schools can facilitate events and services that foster trust and strong relationships between peers, students and their teachers. Strategies to prevent bullying on social media and education on its proper usage may provide some relief in the prevalence of short term mental ill health. As mental health first aid training becomes more commonplace, schools should consider teaching it as part of preparing students for employment.

## 1.12  Government support to find and maintain a job

*Summary of information heard during consultation with the Youth Advisory Group*

***For those who experience or are affected by mental illness, employment can be a daunting prospect. Changes to industrial environments and behaviour of workers can have significant positive impacts on ensuring a holistic, welcoming workplace.***

YAG members suggested that the reduction of stigma and discrimination, both for those seeking employment and those already within employment, is a crucial step. Mental health education and training for employers and employees should be mandatory. This education should not only teach mental health literacy, but also inform workers of easy to access workplace services, and the importance of promoting positivity and resilience, rather than hostility and negativity. There needs to be a change in the workforce mindset; individual productivity and progress should be measured in a way that celebrates small wins and non-financial as well as financial success.

The role of peer support workers is increasing, and can have substantial effect on employment outcomes. Collaboration with employment consultancy organisations, liaison and communication, support and understanding can help to provide existing and potential employers and employees with the necessary mental health help they require.

### Summary of information heard during consultation with CALD community

**Australia has thrived on the contribution of its large multicultural society to various industries. This vibrant success overshadows the fact that for many culturally and linguistically diverse people, gaining and maintaining suitable employment comes with barriers unique to their demographic.**

The CALD community told the Commission how migrants and refugees on visas may lack the education and experiences needed to fulfil particular roles in Australian industries as well as to understand workplace related legislations. This is a frustrating and distressing position for individuals and families, and further complicates other living concerns such as housing.

In consultations, the Commission heard that both government and non-government programs and services need to be better resourced and financed to help multicultural Australians gain job ready skills particularly for those with low English language skills and/or affected by mental illness and/or other disability. These services need to be more readily identifiable, use innovative approaches to engage in learning and should have both improved referral procedures and stronger collaboration. Maintenance of records of skill progression is vital, so that families can, secure better opportunities. This also provides governments with valuable information about the evolving industrial landscape, as well as the makeup of Australia's workforce.

Whilst workplace bullying is not unique to multicultural employees, a cultural background, appearance, and particular belief system can play a significant part behind harassment. This form of negative social behaviour can have longstanding effects on a person's mental wellbeing, and on those who are experiencing mental ill health. There have been examples where these cases are poorly handled or the claims dismissed, further prompting mental distress.

The CALD community consulted with called for action to be taken to investigate occurrences of bullying, backed by appropriate consequences. Training and education should also be integrated into workforce training to better address cross cultural conflicts and to make colleagues more culturally competent and better able to actively take a stance against harassment.

## 1.13   Mentally healthy workplaces

### Key findings from the 2017 SAMHC community consultation

**Workplaces can greatly impact mental health and wellbeing, and there is a need to build on work already occurring to generate and grow mentally healthy workplaces in SA**

The Commission heard about numerous organisations promoting the importance of workplace mental health and wellbeing, and recognising that workplaces can contribute both to protection against and/or development of mental health issues.

Several SA Government departments and private companies reported on wellbeing initiatives in their workplaces in annual reports. Several positive examples of where organisations, both large

and small, had implemented worker wellbeing initiatives suited to the needs of their staff were identified. One example was a dedicated daily spiritual time for all staff in a local Catholic school.

Nonetheless, many South Australians described their personal experiences of workplace stress, bullying or lack of support as contribuing to their own mental health issues. There were also many stories of workplaces not being supportive of people with existing or emerging mental health issues.

South Australians felt that in general the workplace was under prepared for how to discuss mental health issues with staff, how to create mentally healthy workplaces or understand what they may look like, and how to talk to and support people with mental ill-health. The need for additional mental health first aid education and training was identified not just for managers but for all staff, as it is often non-managerial colleagues who are in a position to offer the most support.

People had suggestions for contributing to the creation of mentally healthy workplaces. These ideas included the decision to actively employ people who have experience of mental ill-health, to offer volunteering opportunities to people with experience of mental ill-health to allow them to provide a meaningful contribution and/or as a pathway to future employment, and to allow staff dedicated time to volunteer in the community. It was noted that implementing some of these initiatives may be more difficult for smaller organisations who may not be 'resource rich'.

## *Summary of information heard during consultation with CALD community*

***Workplaces are the forefront of mental wellbeing for many Australians. Therefore, they need to be supportive and safe spaces that have a focus on the wellbeing of employees.***

The Commission heard that when considering the appearance and behaviour of employees within a mentally healthy workplace, the environment should be supportive, and provide equal, fair, and universal rights and opportunities for workers. There should be initiatives to ensure the workload does not contribute heavily to stress and poor mental health. Policies should be adapted to reflect a focus on wellbeing. The workplace should be inclusive and strive to decrease discrimination and stigma. Workplaces should offer education on mental health literacy and first aid, and encourage open dialogue around mental health.

# Response to the framework to enhance mental health and improve participation and workforce contribution

## 1.14 Coordination and integration

### Key findings from the 2017 SAMHC community consultation

***There is a call for greater integration across multiple service sectors and providers to ensure that people receive the care and services they need and do not fall through cracks in the system***

While there were many examples of where state government Mental Health Services, other government service providers, PHNs, GPs, NGOs and the private sector work well together to ensure people's needs are met, often these examples rely on personal relationships rather than systemic structures or processes. In some cases there was said to be a "shaky and tenuous collaboration between NGOs and government", particularly between State MHS and NGO providers of non-mental health specific services for homelessness, employment, disability and aged care support. In other cases, there was a call for greater connection and communication and less silos between government sectors.

Some examples from service providers highlight particular groups where South Australians felt that improved integration would greatly improve outcomes for individuals and the community. For example, people under the Office of the Public Advocate can have complex circumstances including mental ill-health, physical disability, intellectual disability, physical health issues, substance misuse, forensic history, challenging behaviours and the need for support around activities of daily living. Many were reported to remain in acute inpatient mental health settings for extended periods due to difficulty getting a collaborative and 'joined up' approach between agencies, particularly around access to appropriate community housing and care.

Examples were also provided of where people thought integration was working well across services and systems to consider whole of person needs. These included but were not limited to several rural and remote locations where staff in different sectors were more likely to know eachother socially (although this was also seen as a negative for some people who were reluctant to access services where they did not want the whole town to know their situation), the Centre for Disability Health which provides general medical and specialised services to eligible people with dual diagnoses of intellectual diability and mental health conditions, and the Multi-Agency Protection Service (MAPS) which provides coordinated response aroundhigh-risk domestic violence cases.

Several clinicians in youth, adult and older persons mental health services who felt that there should be greater recognition given to the fact that the public system is providing care and support often for people with the most complex circumstances who are likely to require a much greater level of service and sector integration than that which may be required for people in the private sector. In addition, without a shared sense of responsibility for people with complex needs, our police and teachers in some areas felt that they were having to be the "jack of all trades", placing their own physical and mental health at risk.

As part of improving integrated service delivery, there were also calls from people with lived experience and their families, and service providers for a shared data tool, both between government sectors and between government and NGOs, so that service users did not have to re-tell their stories over and over again. It was recognised that there may be privacy concerns around this, and that any shared database would require some level of client and/or carer consent.

A key concern raised by many South Australians was around the lack of adequate continuity of care between State government services, PHNs, GPs and NGOs, with inadequate follow-up on discharge. Numerous stories were told by individuals or family members about their experience of persons being discharged without adequate, or any, planned or actual followup. In many cases this resulted in a worsening of mental health and readmission. Service providers and PHNs felt that services need better ways to follow-up with GPs and provide more tools and resources to help people move back into their community when discharged.

### *There is a call for integrated services offering a continuum of care suited to the needs of the person at the time, aiming to 'intervene before the crisis' wherever possible, and provide crisis care, rehabilitation and ongoing support for those who need it*

The Commission heard a strong message from the South Australian community that mental health services aimed at hospital avoidance should receive increased focus. However, this should not be at the expense of acute hospital based services for those who need this level of support. South Australians with lived experience, their families and carers, NGOs, psychiatrists, mental health service providers, and primary care providers all indicated that crisis respite programs (previously funded but no longer available) had provided a valuable service which allowed people to self refer, "come in for a week or so to sort out their issues" in a non-clinical service environment, and avoid the need for hospital admission in many cases. Many South Australians felt that the current mental health service system was "crisis-driven" due to a lack of investment in options for prevention and early intervention (which are "more difficult to measure").

As well as crisis respite services, greater community support and follow up may reduce the need for hospital presentation or admission. NGOs, psychiatrists and other mental health service providers highlighted the need for more accessible psychosocial rehabilitation programs "that don't have extensive exclusion criteria and embrace working with people with drug and alcohol problems and other co-morbidities". By ensuring people have appropriate community support, tools and techniques to assist them in keeping well when discharged from health services, and by ensuring that people are appropriately followed up, people can be assisted to avoid hospital re-admission. The Commission heard about situations where people had been discharged from hospital following admission for mental illness and/or suicide attempt with no scheduled follow-up, or where a follow-up had been scheduled but the person had not been contacted if they did not attend. We were told that responsibility and accountability for follow-up was unclear and inconsistent.

### *For many people with ongoing mental health issues, continuity of care is important in order to build a therapeutic relationship*

The Commission heard from clinicians and people with lived experience regarding the importance of a consistent therapeutic relationship to assist people in their recovery from mental ill-health and/or for ongoing support for mental health. A key factor in establishing therapeutic relationships is the ability to engage in an ongoing manner with the same person or service providing care. The ability to establish therapeutic relationships was being compromised for many people due to the

cap on Medicare funded psychology services, and also by a lack of staff continuity between community and hospital services. Some NGOs reported that they follow "people into and out of services, which provides stability, continuity and ongoing connection in and out of hospital by liaising with ward staff and family."

For South Australians with ongoing mental health issues, the current system split and change of worker, practitioner or provider at times of key life transition points could be distressing. This includes the age-based split between childrens, adults and older persons services.

***People who experience particular kinds of mental illness may require targeted and ongoing support; these may include people with severe and complex mental illness, borderline personality disorder, eating disorders, and people experiencing co-existing mental illness, substance misuse or other co-morbidities***

The need for a coordinated approach for people with severe and complex mental illness was strongly supported by South Australians including those with lived experience, their families and carers, NGOs, mental health service providers, primary care providers, and other support services and agencies. People with complex circumstances may have severe mental illness, treatment resistant psychotic symptoms, intellectual or other disability, physical health issues, substance misuse, forensic history and/or exhibit challenging behaviours. Some people with complex needs do not readily engage with services and systems, while others remain for extended periods in acute inpatient services, and place a heavy demand on such services, due to a lack of appropriate options for community housing and support or alternative models of care and support. These South Australians may not be eligible for disability services and can "fall through the gaps in service provision" due to difficulty in establishing a coordinated approach to provision of support across services.

***Alongside reports of mental health services working well, many mental health service staff are frustrated by their inability to provide what they believe is integrated, holistic, person centred and recovery oriented care due to what was reported as risk-averse cultures, lack of available and consistent training opportunities, and inadequate clinical time available for building therapeutic relationships***

Staff in several NGOs and also state-run mental health teams spoke about their positive work culture, longevity of staff in positions, and collaborative approach to "stopping at no point" when providing services which engage and support people in their care. However, staff in other health services communicated that services are risk-averse or restricted by budget, and that staff do not feel supported to develop or try innovative approaches to providing or improving therapeutic care. While systems to ensure accountability for service provision and care are important, "accountability has a downside as staff contact time has reduced from over 60% to 30% in 20 years".

Leaders of mental health services stated that they would welcome the opportunity and the time to be creative rather than being forced to always make reactive decisions, often based on "the need to cut spending but still create positive change". Mental Health Service staff indicated that staff lack resources and time to engage in proactive rather than reactive care, and are getting burnt out due to high caseloads and insufficient time to provide the care that they would like to. There are increasing numbers of people being accepted into mental health services with a range of drug and alcohol issues, and mental health service staff feel inadequately trained in this area and reported that they rarely have access to DASSA staff in their workplaces.

South Australians with lived experience and also clinicians indicated that where clinicians were able to take the time to provide genuine, kind and dignified care this was extremely helpful to achieving therapeutic outcomes. South Australians stressed that a respectful and dignified relationship between an individual and clinician (be that a GP, psychiatrist or allied health provider) de-emphasised the traditional patient role of passivity, obedience and compliance, and emphasised the importance of the person's own lived experience and input into decisions regarding their care.

## 1.15   Funding arrangements

### *Key findings from the 2017 SAMHC community consultation*

***Current funding models do not always recognise the importance of continuity of service provider, or encourage sharing and/or innovation***

The Commission heard time and again of the importance of NGOs in the provision of non-clinical community support services for people with mental health issues. However, the short term funding models for NGOs and also for specific regional or Aboriginal programs, leads to difficulty attracting and retaining staff and can result in lack of continuity of service provider, inability to forward plan, inability to build relationships which may be critical to longer term program outcomes, and difficulty collecting data to inform these longer term outcomes. Competitive funding arrangements now mean that NGOs are often in a position where they are competing for funding, and this can impact the ability of NGOs to work together or share innovative practice which may be in the best community and client interests.

Even within government-run services, the Commission heard that there has been a shift in focus from service delivery to ensuring ongoing funding, and this has impacted opportunities for collaborative or shared approaches to developing best practice in care delivery, and also resulted in little capacity for innovation. The Commission heard that based on current funding models, specified funding is generally not available to support resourcing and time required for integrated service delivery across departments and organisations.

The shift to more individualised fee-for-service funding arrangements under the NDIS has forced many NGOs to think creatively and be more innovative in the way they are providing services. While this is seen as positive, it was emphasised that there is still an essential need for stable and ongoing core service investment to ensure that people who need help do not fall between service provider gaps.

During the 2017 consultations, people from all areas consulted spoke about their concern about the roll out of the NDIS and the changes it would have on the mental health service system in SA. While the rollout of NDIS has progressed significantly in thelast two years, the community still epxresses concerns about the impact of the NDIS on the mental health service system in SA.

Many South Australians believe that the current cap on Medicare-funded psychologist sessions per year was in many cases insufficient. The Commission also heard that current Medicare rebates for GPs may lead to a financial disincentive for GPs to work with mental health issues – "mental health frequently gets lost in GP land as it opens up a pandora's box that cannot be fixed in ten minutes". While GPs are promoted as the first contact point and are well placed to act in a primary care role, they often do not have the time or understanding to recognise or explore the background trauma or other issues that may be contributing to mental ill-health presentations.

*People asked for strong leadership and clear governance, responsibility and accountability for a whole-of-government approach to mental health and wellbeing, with mechanisms in place to oversee resourcing and implementation of government-wide strategic actions*

Although South Australians welcomed a whole-of-government approach to mental health and wellbeing, and agreed that mental health and wellbeing is "everybody's business", concerns were raised that this approach requires very clear articulation of responsibilities and means of accountability. Without this there is a risk that no organisation or service will be held accountable for delivery or implementation of reforms and initiatives.

Several South Australians working within state mental health services are seeking re-instatement of an overarching governance and executive structure for mental health services across the State. This would provide centralised capacity and accountability for ensuring state and national plans and policies are implemented consistently across LHNs, whilst still allowing for potential differences in regional needs. It would also allow for big picture, statewide thinking alongside that provided by other independent statewide bodies such as the SA Mental Health Commission and the SAHMRI Wellbeing and Resilience Centre. For example, suggestions were made regarding the establishment of centre(s) of excellence in mental health in SA which serve to create and implement good practices, with strong links to universities and research.

When planning mental health and wellbeing services at a state and local government level, the importance of the physical and structural environment in helping people to engage with services was emphasised. For example, many people reported that the colours and physical space at headspace services was inviting for young people. A strong request from several organisations that there is a need for separate spaces for females and males in acute mental health units, as females are currently being placed at high risk in some of these environments.

## 1.16  Measurement and reporting of outcomes

### *Key findings from the 2017 SAMHC community consultation*

*It would be helpful if data collections and performance indicators were applicable to all services, collected meaningful and useful information, and connected the person's journey between as well as within services*

In talking to stakeholders across SA, the Commission heard a call for performance measures that are outcomes rather than activity focussed, with comment that key performance indicators (KPIs) focussed on emergency department hours or admitted bed days may not always be the best measure of performance.

South Australians suggested that SA public mental health services should remain committed to using data to inform decision making around service development, performance and resource utilisation, and to progress development of information systems in line with the national agenda. However, it would be valuable to have the ability to trace patient journeys and outcomes through currently disparate data sets across sectors and between community care (including NGOs), primary care and specialist care. This should involve people with lived experience directly in their articulation.

The integration of local and state level data could then support funding allocations and improve knowledge of service or outcome trends. Information systems may need to be adapted to capture

relevant data, which should only occur based on coordination and cooperation with clinicians to ensure minimisation of any additional data entry burden.