



# Mission Australia

Submission to the  
*Inquiry into Commonwealth Funding and  
Administration of Mental Health Services*

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## Introduction

Mission Australia is a national not-for-profit community services organisation. Our vision is to see a fairer Australia by eliminating disadvantage and enabling people in need to find pathways to a better life. We have been working for over 150 years and currently operate more than 500 community and employment services from 350 sites in metropolitan, rural and regional Australia. In 2009-10 our services supported about 300,000 Australians from a diversity of communities.

While Mission Australia is not a specialist provider of mental health services, mental health and wellbeing are at the core of our service areas – children and families, young people, homelessness, life and work-ready skills, and employment.

We believe that all Australian children should experience a safe, healthy and happy childhood. In 2009-10 our *Early Learning Services* provided affordable childcare to 2,243 children, a high percentage of whom were considered to be “developmentally vulnerable”. Our range of youth programs support young people with drug and alcohol problems or who had experienced family breakdown, homelessness and mental illness. For the last nine years Mission Australia has been conducting an annual survey of young Australians, the largest of its kind, and in 2010 over 50,000 youth aged between 11 and 24 participated. Physical and mental health was highly valued by a third of respondents; coping with stress was the third ranked issue of personal concern, while alcohol and drugs was the second top national issue identified by young people.<sup>1</sup>

Mission Australia is also supporting people with mental health issues through the *Personal Helpers and Mentors Program* (PHaM), which is part of the Council of Australian Governments Mental Health Strategy. PHaM aims to help people with mental illness to manage daily activities and access services. In NSW we are a provider of the *Housing and Support Initiative* (HASI), funded by the NSW government. HASI provides housing, support and mental health services to clients through a coordinated model. Also in NSW, our *Michael Project* which works with homeless men in the Sydney region, combines homeless and accommodation services, assertive case management and specialist allied health and support services. A baseline survey completed by a cohort of clients found that half had been diagnosed with a mental health disorder other than a substance use disorder, 96% showed high to very high levels of distress, 95% had experienced one or more traumatic events, and half reported a substance use disorder diagnosed by a health professional.<sup>2</sup>

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<sup>1</sup> Mission Australia (2010). National Survey of Young Australians 2010 – Key and emerging issues. Mission Australia, Sydney

<sup>2</sup> Mission Australia (2010). Increasing our understanding of homeless men: The Michael Project. Mission Australia, Sydney

A snapshot of data drawn from a sample of more than 10,000 clients from Mission Australia's Community Services in January 2011 highlights the extent of mental illness across our client group. Many clients do not disclose mental health issues, either they do not know themselves or they choose not to disclose, or we are not yet in a stage of our relationship where it has been disclosed (we collect data progressively through a case history).

- 14% of our clients in non-mental health services have disclosed to us that they have a mental health issue;
- 17.5% of our clients, including those in mental health services, have disclosed mental health issues to us. Of these clients, 28% are 17 years or younger (that represents 12% of all clients in this age group); 80% are aged 18-54 years; and 9% are 55 years and over;
- 7% of people with mental health issues in our services are from culturally a linguistically diverse (CALD) backgrounds;
- 10% of people with mental health issues in our services are Aboriginal Australians.

Mission Australia's service delivery, programs and advocacy are informed by our Research and Social Policy Unit (RSPU). RSPU focuses on best practice and leading national and international research to identify existing and emerging social needs and assist in the development of innovation and effective responses to these needs. These activities also enable Mission Australia to prepare submissions that are informed by the synthesis of practice wisdom with primary and secondary research.

## **Comments on Government's Funding and Administration of Mental Health Services**

Mission Australia welcomes the opportunity to comment on the Government's funding and administration of Mental Health Services. Based on our experience in service delivery and advocacy for the most disadvantaged people in Australia, we concentrate in the following terms of reference:

### *The Government's 2011-12 Budget changes relating to mental health*

Mission Australia welcomes the Commonwealth Government's commitment to mental health reform. The 2011-12 federal budget's \$2.2 billion mental health program, which includes \$1.5 billion in new money, is a good starting point for addressing the extent of the mental health needs of the Australian community and the current gaps in service delivery.

In particular, we welcome the package's support to:

- People with more complex and persistent mental illness through the provision of integrated assessment and additional Personal Helpers and Mentors services across the country. The Personal Helpers and Mentors Program (PHaM) run by Mission Australia in Newcastle (NSW) has assisted participants to gain increased and timely access to appropriate support services, improve their life skills, improve relationships with families and carers, and have an increased connection with their community. The case study below highlights the impact of the PHaM program.<sup>3</sup>

Barry<sup>4</sup> has been a participant with Mission Australia's Newcastle PHaM for approximately 2 years. When PHaM first had contact he was vulnerable and mentally unwell, he had been badly beaten up by several men and he could not return to his home for safety reasons. PHaM referred him to a men's hostel for temporary accommodation and began working with him towards recovery. Barry now has permanent housing, is employed, works on his physical and mental wellbeing by attending a gym regularly, is aiming to get a boat licence and has offered some support and encouragement to younger participants. Barry's parents have recently taken a 3 month holiday which they have been unable to do previously as they felt they needed to be always there for Barry. Barry wrote the following poem about PHaM:

*Need a hand someone to care  
To make the blues and trouble rare  
We'll be there through thick and thin  
To make you smile a winning grin  
Need to talk that's why we're there  
To help you see and make life fair  
Don't be afraid to ask for help  
When life is dragging you down you felt  
And if it's family you find you need  
To help you sow and plant the seed  
So talk to us we are Fam  
To fill your life and make it grand  
You're not alone let us take you  
To your limit, make life so true  
So please call us that's why we're there  
To help you through and show we care*

- Mental health programs and services for young people through the expansion of the *headspace* model, and the establishment of additional Early Psychosis Prevention and Intervention Centres (EPPIC) around the country. The National Youth Mental Health Foundation (*headspace*) has shown that young people are likely to accept the recommendation or referral of family and/or friends to seek appropriate mental health support when mental health

<sup>3</sup> Mission Australia (2010) Fact Sheet: Newcastle Personal Helpers and Mentors. Mission Australia, Newcastle.

<sup>4</sup> All the names in case studies have been changed

services are both available and accessible.<sup>5</sup> *Headspace* provides a specialist program for young people (and they connect well with young people). The program has shown significant positive outcomes but is not available in all of the areas that we provide an outreach to. Mission Australia welcomes the announced funding to achieve complete national coverage of the program.

In addition to the mental health programs available to young people, Mission Australia believes that further strategies could be implemented to support young people who have a mental illness or who live with a parent or guardian with a mental illness. As stated by one of our service managers in regional Queensland:

*The onset of a mental illness for young people is sometimes recognised when the young person presents with school refusal. Because of the isolation they face, young people often do not access support and the progression of the mental illness is left untreated. There are major repercussions for young people and their families in situations where the young person has disengaged from education. Further assistance could be resourced to provide mental health practitioners in schools.*

*A mobile service to conduct home visits by mental health practitioners would be advantageous. Support given to young people when a parent is experiencing mental health issues would also be of assistance. Quite often, young people are required to take over the role of parenting when a parent has an episode of mental illness; when the parent recovers the young person is required to revert to being a sibling and this role reversal often causes major tension and conflict in the family. Many of the young people who have experienced this situation have reported to our service that they would like to participate in a program that provides a mentoring role.*

- Increasing economic and social participation for people with mental illness through building the capacity of employment service providers to identify and support people with mental illness to secure employment. Mission Australia is one of Australia's largest providers of Job Services Australia with 93 locations across the country. Currently, 7.1% of our Employment Solutions case load has an identified mental illness that presents a barrier to employment. Mission Australia's submission to the 2008 National Mental Health and Disability Employment Discussion Paper strongly supported "developing the skills of those working in the mental health and employment services areas (and other related areas such as housing, drug and alcohol, family support) to work together to achieve a range of employment, health and social inclusion

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<sup>5</sup> Muir, McDermott, et al (2009). Independent evaluation of headspace: The National Youth Mental Health Foundation. Social Policy Research Centre, University of New South Wales, Sydney.

outcomes in initiatives such as supported employment programs.”<sup>6</sup> Mission Australia has developed and implemented a number of innovative responses such as the Urban Renewal Employment Enterprise Program (UREEP) and Catalyst Clemente which are achieving significant outcomes for disadvantaged clients, including those with a mental illness.

### *Changes to the Better Access Initiative*

Prior to the introduction of the Better Access Initiative in 2006, the majority of our clients who were experiencing considerable disadvantage could not afford access to mental health care. Better Access has given clients the ability to access mental health services through Medicare via GP referrals. However, our experience indicates that take up of the Initiative across the country is patchy and it is not well understood by both GPs or by workers in the field.

Depending on the client group, Mission Australia’s services have seen a diversity of responses to the Better Access Initiative. In relation to young people, the manager of one of our services in regional Queensland has seen a positive response:

*The number of young people who access this type of service has increased because of the ease to be referred, the cost associated, and the shorter wait list when compared to other services such as Child and Youth Mental Health Services (CYMHS). We have found that Better Access is seen by young people as less invasive, does not have the stigma attached compared to being referred to other services, and provides the young person and families with autonomy to self refer. The continuity of mental health care provider and the capacity of the initiative to provide assistance to the whole family (rather than only the young person) are also highly valued by the users of Better Access.*

Adult participants within the Personal Helpers and Mentors Program (PHaM), many of whom have long term trauma or behavioural issues, face particular challenges when accessing the Better Access mental health plan. A Mission Australia support worker in Tasmania stated that:

*[For many of these clients, their mental health issues] take time and effort to be addressed. They also find it hard to engage with people and trust people within the industry due to past experiences e.g. admission to government mental health services for treatment against their wishes or bad experiences with mental health services. It may take up to four visits before work can really begin as they will only disclose as they feel they can trust and feel safe. Childhood trauma and abuse affect a large number of*

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<sup>6</sup> Mission Australia (2008) Response to the National Mental Health and Disability Employment Discussion Paper, June 2008.

*[PHaM] participants and these people are often unable to pay for support services. For the older persons within our program it may be an issue of having to travel for service and the cost of getting there as well as having to pay for the service make the changes they seek unsustainable if requiring long term psychological assistance.*

The announcement of the proposed changes to the Better Access Initiative of capping allied mental health sessions to 10 from 12 (or from 18 under the 'exceptional circumstances' conditions of the existing scheme) is already having an impact on our clients. According to one of our service managers in regional NSW:

*Our PHaM clients are reporting that the reduced number of Medicare visits is having a major impact, as most of them have chronic mental health issues and the psychologist will not see them because it cannot be ongoing which is what they need. Many clients state that they do not want to start seeing a psychologist then to have to stop after ten visits, as they are concerned about opening Pandora's Box so to speak.*

The difficulties faced by adult clients with chronic mental illness, including the lack of access to psychiatric care in some areas, were also highlighted by a Mission Australia staff member in Tasmania:

*Accessing six sessions with the potential for ten sessions of allied mental health services within a one year time frame reduces the [PHaM] participant's chance of long term behavioural change. [Even though] the government is making available 50 visits per annum per person for psychiatric services to be rebated through the Medicare system [psychiatric care is not always guaranteed]. This all sounds good in theory but [in many regional areas] we have a shortage of psychiatric care with locums often filling in for short contractual periods. Access to psychiatric care is limited and waiting lists apply. For the people in these areas more psychiatrists would need to be employed and access to them would need to be addressed so that the need for service can be dealt with promptly.*

Ensuring the availability of professionals from both Psychiatry and Allied Mental Health disciplines will be of long term benefit to the recovery and sustained change of people with mental illness.

From a Mission Australia service perspective, the Better Access Initiative has not had a real impact on Aboriginal and Torres Strait Islander clients, many of whom have high complex needs. A service manager in regional Queensland stated that:

*I feel that the Better Access Initiative has not impacted at all on our client group. Most of our client group have high complex*

*needs and a majority identify as Aboriginal, Islander or both, and they do not access the mainstream services. The allied mental health treatment services are aimed for mild to moderate mental illnesses. The service available for those with severe mental illness [in this region] within the homeless sector is the Homeless Health Outreach Team [which is part of the Street to Home homeless service].*

Mission Australia believes that the Better Access Initiative could be better utilised by the clients we work with. This could be through targeting a higher level of services to those most in need, rather than a one-size-fits-all approach.

### *The adequacy of mental health funding and services for disadvantaged groups*

Mission Australia welcomes the additional resources announced in the National Mental Health Reform to address the mental health needs of Indigenous Australians. The significant disadvantage of Aboriginal health and social determinants has been widely documented.<sup>7</sup> Aboriginal and Torres Strait Islander peoples report significantly higher levels of stress than the rest of the Australian community, and experience harmful rates of alcohol and other substance abuse. The rates of both hospital admissions and death due to severe mental illness in Indigenous Australians adults are considerably above the rates of the non-indigenous Australian adult population.<sup>8</sup>

The experience of Mission Australia's services working with Aboriginal and Torres Strait Islander communities in regional and rural areas is that there is a high need for holistic service models with the capacity to support clients with high needs not only in terms of their mental health but also with their living arrangements, including basic living skills. For example, in Far North Queensland:

*Many of our clients present with dual diagnosis or may have an acquired brain injury and simply cannot sustain housing on their own. There are no facilities in these areas able to provide 24 hour support for clients with severe mental illness and high complex needs (Mission Australia service manager regional Queensland).*

In addition, Mission Australia believes that there is a clear need to develop a sustainable Aboriginal mental health workforce through the implementation of

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<sup>7</sup> Purdie N, Dudgeon P and Walker R. (Eds) (2010). Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. Australian Council for Educational Research, the Kulunga Research Network, and Telethon Institute for Child Health Research.

<sup>8</sup> Parker R (2010) Australian Aboriginal and Torres Strait Islander Mental Health: An Overview. In Purdie et al. (Eds) (2010). Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. Australian Council for Educational Research, the Kulunga Research Network, and Telethon Institute for Child Health Research.



strategies that recruit, train, support and retain Aboriginal mental health workers and professionals.

Similar needs for culturally appropriate services apply to culturally and linguistically diverse (CALD) communities, including those communities from refugee backgrounds. Australian literature on access to mental health services among CALD consumers reports: higher rates of involuntary and lower rates of voluntary admissions by consumers from CALD backgrounds; lower rates of access to community and inpatient services compared with Australian-born people; longer periods of hospitalisation among CALD consumers, and; CALD consumers are more likely to present for treatment at the acute, crisis end of treatment.<sup>9</sup>

The recent Multicultural Mental Health Australia (MMHA) consultations on mental health services,<sup>10</sup> and feedback from a coalition of non-government and government multicultural health and mental health services, have identified key gaps in the provision of culturally appropriate services, including:

- the lack of availability of mental health trained interpreters;
- the need to train mental health staff in cultural competency, including the appropriate use of interpreters, and the contextual issues of the refugee experience;
- the need to increase participation of CALD consumers and carers (including those from refugee backgrounds) in the planning and implementation of mental health programs and services;
- the need for more multicultural and ethno-specific service models to be funded, including fostering the growth of a bilingual mental health workforce;
- inconsistent models of implementation for the Access to Allied Psychological Services (ATAPS) Program across Divisions of General Practice which has led to inequitable or non-existent service delivery for people from CALD and refugee backgrounds. For instance, data provided late last year by the University of Melbourne to General Practice Queensland reported that less than one per cent of referrals to ATAPS in Queensland were people from CALD backgrounds.

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<sup>9</sup> Multicultural Mental Health Australia (2010). The State of Play: Key mental health policy implications for CALD communities in Australia – Findings from MMHA consultations. MMHA: Parramatta, NSW.

<sup>10</sup> Multicultural Mental Health Australia (2010). The State of Play: Key mental health policy implications for CALD communities in Australia – Findings from MMHA consultations. MMHA: Parramatta, NSW.

Mission Australia's experience working with people from CALD backgrounds supports the above findings. A service manager in regional Queensland highlighted that:

*I feel that CALD mental health needs further development and resourcing. There are no CALD practitioners experienced in working with young people and/or families.*

### **The need to provide holistic treatment and support for the co-morbid conditions of substance misuse and mental illness**

Mission Australia believes that a significant omission in the Mental Health Reform 2011-12 Budget is the failure to address the fragmentation in the provision of services when substance misuse occurs in conjunction with other mental health conditions. This is a serious gap given the high prevalence of co-morbid mental health conditions and drug and alcohol addiction. National statistics indicate that approximately one-third of all people identified as having substance misuse issues are also identified as having at least one co-occurring affective or anxiety disorder. Further, people with co-morbid conditions are at greater risk of relapse, of both their substance use and other mental health problems. One in four young people experience a mental health condition (including substance use disorders) over any 12 month period: the highest prevalence of any age group. Among these young people, approximately half suffer from a substance use disorder.<sup>11</sup>

Despite the common acknowledgement of the value of a co-morbid approach in relation to substance use and other mental health conditions, the policy response so far has been fragmented. Health and mental health services are usually structured to provide either 'sequential' (e.g. treated first for an overdose in an emergency room and then referred to a mental health service to treat underlying depression) or 'parallel' (i.e. both issues are managed simultaneously, but by different service providers) treatment. This fragmentation leads to many clients dropping out before the complexity of their issues can be fully addressed.

### **Mission Australia's Triple Care Farm**

In response to these challenges, Mission Australia's Triple Care Farm is a residential program for young people (aged 16-24 years) who are experiencing problems with both substance abuse and mental illness.<sup>12</sup> The farm has been operating for 20 years and is located in the Illawarra region of New South Wales. The approach of the program is best described as a holistic co-morbid treatment model because it seeks to observe and understand the social, environmental, physical, mental and vocational antecedents and after-effects of addiction.

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<sup>11</sup> Australian Bureau of Statistics (2007) National Survey of Mental Health and Wellbeing: Summary of results, Australian Government, Canberra.

<sup>12</sup> Mission Australia (2011) Triple Care Farm: A safe place for change 1989 – 2009. Mission Australia, Sydney.

The clients at Triple Care Farm, who are referred to as students, progress through three stages: (i) the *Gateway* stage focuses on goal setting and relationship building; (ii) in the *Explorer* stage, students work towards the set goals that will include participation in some accredited training; and (iii) at the *Outbound* stage, students transition back into the community. Students participate in three program elements:

- Residential activities: focus on the acquisition of life and living skills;
- Therapeutic activities deal with the medical, psychological and behavioural issues associated with mental illness and addiction; and
- Engagement and well-being programs seek to encourage healthy living and physical fitness, and re-engage students with education, learning and work.

All of these stages are underpinned by flexibility and a strong philosophy of individual responsibility, with students required to actively participate in their own treatment and reflect on their own progress. Involvement in the program can span up to 12 months, depending on the individual student's needs. There is a pre-farm component where staff of the program work with the student while they are still in their local community, for anywhere up to three months before they formally relocate to the farm. Students reside at the farm for around three months and then move to the Stepping Out aftercare program, which is available to students for up to six-months after they graduate from the program. The aftercare program provides ongoing support to the students once they have returned to their community. An important feature of Triple Care Farm is that it emphasises the rebuilding or development of familial relationships wherever is possible or appropriate. This approach is based on the wide body of research which shows that when family can be involved positively in rehabilitation, this decreases the chance of relapse.

#### *Triple Care Farm's key achievements*

From 2005 to 2009, a total of 399 young people participated in the Triple Care Farm program. Of these, 160 (40 per cent) elected to receive additional support by participating in the aftercare program. Key outcomes among this aftercare cohort of students are shown below:<sup>13</sup>

- Substantial reduction in alcohol use: 46 per cent used alcohol at chronic levels at intake; only six per cent stated they still used alcohol at chronic levels three months into the aftercare program. This overall reduction was maintained at six months into the aftercare program.

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<sup>13</sup> Mission Australia (2011) Triple Care Farm: A safe place for change 1989 – 2009. Mission Australia, Sydney.

- Substantial reduction in illicit drug use: 88 per cent used at least one drug chronically when entering the program; only six percent after returning to the community.
- Significant reduction in the severity and intensity of distress.
- Increase in satisfaction with life in general: the greatest increase was reported in their satisfaction with health and work. Significant increases were also reported in areas such as self-esteem, goals-and-values, money, play, learning, helping, creativity, and relatives.
- Employment outcomes: 91 per cent were unemployed when entering the program; 43 per cent had entered some form of paid employment three months after graduating and these outcomes were maintained at the six-month interval.
- Housing outcomes: at intake, 31 per cent were homeless or in transient accommodation; at three and six months into the aftercare program, only one person reported being homeless. The proportion of students in independent housing increased from 9 per cent at intake to 25 per cent six months after leaving Triple Care Farm.

The success of the Triple Care Farm program is also evident from Carl's story below.<sup>14</sup>

Carl was 18 when he applied to the Triple Care Farm program. He lived with his mother who had been supportive throughout his life. During childhood he was diagnosed with Aspergers' Syndrome. Carl began using cannabis at 12 years of age and had attempted suicide twice in less than six years. Carl reported poly-drug use (cannabis, oxycodone, amphetamines, benzodiazepines, ecstasy) and had tried heroin, methadone and cocaine. In clinical terms, Carls' substance use is co-morbid with, and perpetuated by, an underlying Generalised Anxiety Disorder.

Carl applied to Tripe Care Farm when he felt that things had increasingly "gotten out of hand" at home and his "mental state had deteriorated into nothing". During his stay at Triple Care Farm he completed 12 sessions of a combined Cognitive Behavioural Therapy and Solution Focused Therapy, as well as psycho-education addressing anxiety and phobias with a registered psychologist. The consultant psychiatrist offered psychopharmacology to help manage and maintain a calm emotional and cognitive state. Carl's physical health was monitored by a visiting General Practitioner. Carl completed a range of groups addressing alcohol and other drugs (AOD) use, communication skills, healthy lifestyle choices, harm minimisation and relapse prevention. He also embraced the non-clinical program focusing in acquiring better life and living skills, improving his education (literacy and numeracy skills in particular), and sport and recreation activities. He also completed projects in the wood workshop, and excelled in the catering and food preparation courses. He was accepted into TAFE courses and has since obtained his Higher School Certificate. He began to work voluntarily at a local reptile park where he was later offered part-time employment. In his final weeks at Triple Care Farm, Carl was having regular family visits, which improved the relationship between himself and his mother.

<sup>14</sup> Mission Australia (2011) Triple Care Farm: A safe place for change 1989 – 2009. Mission Australia, Sydney.

Carl has left Triple Care Farm with a new set of skills to help him cope with family relationships and his underlying anxiety issues, and to manage the contingency of relapse. Upon leaving the farm, he had appointments with his counsellors and had a clear plan of action should he relapse with substances. Carl reported to his aftercare worker that he had relapsed upon returning home for approximately two weeks. With the support of his mother, counsellors and aftercare worker, he has since regained abstinence from substances and has been clean for 11 months. Carl continues to see *headspace* for counselling – both mental health and AOD. He is also undertaking job education programs. Carl continues to live at home with his mother, sister and niece and has commented that his relationship with his family has greatly improved.

The outcomes detailed above indicate the profound improvements made by many young people who attend and graduate from Triple Care Farm. The program has shown immense ability to adapt and has become a treatment facility of national significance for young people from all over Australia. The operational model at Triple Care Farm is evidence-based and involves a process of continual service review.

In a policy context, Triple Care Farm has remained at the forefront of current thinking on high quality strategies to address youth, drug and mental health concerns in the community. The complexity of drug addiction and mental illness means that the services required to treat these conditions can be costly. However, mental illness and substance abuse are also costly. In 2009, the estimated financial cost of mental illness (including substance use disorders) in people aged 12-25 was \$10.6 billion.<sup>15</sup> More importantly, the long-term rewards associated with successful treatment for the young people as individuals and the community as a whole are immense.

Mission Australia believes that the success of the Triple Care Farm co-morbid treatment model warrants serious consideration within the current Mental Health Reform. As stated recently by Professor Patrick McGorry (AO), “as we enter a period of mental health reform, services like Triple Care Farm provide a vision of what can be achieved by addressing mental illness and substance misuse in an integrated, holistic way”.<sup>16</sup>

### *Increasing economic and social participation for people with mental illness*

Mission Australia also welcomes the additional funding announced to enhance the ability of employment services to identify and assist people with mental illness to gain employment. As one of the key players in the provision of employment services, Mission Australia engages with a high number of clients with presenting mental health conditions who are in need of specialist support services. Many of these clients are not linked into appropriate mental health support when they come into contact with our employment services and programs.

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<sup>15</sup> Access Economics (2009) The economic impact of youth mental illness and the cost effectiveness of early intervention. Access Economics Pty Limited.

<sup>16</sup> Mission Australia (2011) Triple Care Farm: A safe place for change 1989 – 2009. Mission Australia, Sydney.

Mission Australia's social enterprise programs, such as the Urban Renewal Employment Enterprise Program (UREEP) and Greener Futures often work with participants with a mental illness. For many, mental illness is their biggest barrier to sustainable and meaningful employment. Our social enterprise programs have been highly beneficial for participants with mental health conditions.<sup>17</sup> As stated by one of our staff members in the Urban Renewal program:

*[UREEP] outcomes for participants vary from full engagement back into the workforce, to partial engagement, and at times in the minority, simply a more connected and stable state of health.*

*Social enterprise support workers can be an extremely important and valuable link in the industry for a person to (i) engage with a service or treatment for the first time, (ii) continue to assist to help a person maintain a service or treatment, and (iii) assist a person in completing a treatment or service. This is because of the intense and holistic case management approach, the trusted relationship that can be achieved with the participant, the long period of time and open ended approach the workers can engage with the participant and the support systems and environment available to the participant [including mental health services]. We have found that participants that are both working and engaged appropriately with mental health support, over a consistent and sustained period of time, develop and improve rapidly in all areas of their lives.*

## **Recommendations**

Mission Australia welcomes the Government's commitment to mental health reform and recognises the package outlined in the 2011-12 Budget as a good starting point for addressing the mental health needs of the Australian community. However, through this submission we have identified a number of gaps in the announced budget changes relating to mental health. To address these gaps, Mission Australia recommends:

- **The funding and implementation of successful models of care for people with co-morbid substance misuse and other mental health conditions.**

Of particular significant is the absence in the package of strategies to address the fragmentation in the provision of services when substance misuse occurs in conjunction with other mental health conditions. Co-morbid mental health conditions and drug and alcohol addiction are highly prevalent in the Australian community, and there is an urgent need to provide holistic treatment and

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<sup>17</sup> Mission Australia, Victorian Department of Planning and Community Development, and the Centre for Public Policy (2008). Working for Renewal: An evaluation of Mission Australia's UREEP, a social enterprise and transitional labour market program. Mission Australia, Melbourne.

support to this population group. In this submission we have described a success story: Mission Australia's Triple Care Farm program for young people with drug addiction and mental illness has shown remarkable improvements in the reduction of substance abuse, increased participation in employment, education and training, improved stability in accommodation, and improved psychological health for graduates. The aftercare component of the program also helps to reduce the risk of relapse when graduates return to their home and community environments. The success of this program model deserves serious consideration within the current mental health reform.

- **Additional mental health programs and services for young people in schools, including programs that provide a mentoring role for youth who live with parents with a mental illness**
- **The Better Access Initiative could be better utilised through targeting a higher level of service to those population groups most in need, rather than a one-size-fits-all approach**
- **Better access to allied mental health and psychiatric care to people in rural and regional areas, including holistic service models for Aboriginal and Torres Strait Islander clients with severe mental illness and high complex needs**
- **Implementation of strategies that develop and support a sustainable Aboriginal mental health workforce**
- **Funding and implementation of programs that provide culturally appropriate services for Australians from CALD and refugee backgrounds, including supporting the availability of mental health trained interpreters, and developing a sustainable bilingual mental health workforce**