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Background information and barriers

The NDCO consulted various stakeholders within Northern WA, regarding barriers and strategies in the arena of mental health and work force participation. The following services and organisations provided feedback;

-Kimberley Mental Health and Drug Service (KMHDS)
- Kimberley Personnel (Disability Employment Service)
-Nindalingarri Aborginal Health Service
-Kimberley School Psychologist Team
- Kimberley District Education Office (student services management)
-Principals from 6 remote schools, representing Catholic, state and independent schools
-Gooyal ('Get Out of Your Abode and Live'- a Network made up of various local people with disability)
-Pilbara Joblink

The views, experiences and feedback from these stakeholders have been collated and depicted below.

Mental health and social and emotional wellbeing problems are one of the biggest barriers to living a full and healthy life in our communities and being able to participate in vocational training or employment is fundamental to living a healthy and productive life.

STATISTICS

- One in five people will suffer from a mental health condition at some point in their lives and in the Kimberley region, mental health is an even greater issue:

- The proportion of people with a known mental health condition in the Kimberley is 1.5 times greater compared with the rest of WA (Mental Health Information System 2007).
- Aboriginal people are over-represented in acute mental health care, comprising 70% of hospital admissions for mental health conditions in the Kimberley and 60% of community mental health clients compared with 42% of the total population (Mental Health Information System 2003-2008).
- The suicide death rate for people in the Kimberley is 2.33 times higher compared with the State population (ABS Mortality Data 1997-2007). Anecdotally this figure has increased significantly since this data was available
- The hospitalisation rate due to attempted suicide/self-harm is 2.7

times higher compared with the State population (WA Hospital Morbidity Data System 2000-2008).

- Both these differences are due to the significantly higher suicide mortality and attempted suicide/self harm rates for Kimberley Aboriginal people.
- Less than 10% of individuals accessing Kimberley based mental health services are in any form of work and although this figure varies from time to time generally is around this mark. The majority of our clients are indigenous people with multiple barriers to community engagement including mental illness, alcohol and drug dependence and social disadvantages that acts as. Our clients and their families have asked us to create a place where they can gain skills and confidence by participating in meaningful therapeutic clinical rehabilitation activities, social and recreational programs and supported employment opportunities
- Broome has an estimated population of 15,386 people in Broome and an unemployment rate of 5.1% (Kimberley Development Commission 2009). Our partner employment service provider, Kimberley Personnel, has established that 40% of unemployed people in Broome cannot return to mainstream work due to social and emotional wellbeing issues.
- In the last four years not one job seeker with mental health illness has been referred to the Disability Employment Service, servicing the entire east Kimberley region (a region the size of Victoria).

BARRIERS IDENTIFIED

- A key problem that arose during recent consultations regarding mental health barriers (2009) was the lack of "things for our kids to do to get well again".
- People with a mental illness in Broome, who may previously have been high-functioning and employed, are now unable to recover from their illness and reengage with the community due to a lack of rehabilitation services and following on from that supported employment opportunities. The result is a large group of chronically unwell, long-term unemployed residents who revolve in and out of hospital and who have little hope for the future.
- The Kimberley/Pilbara regions do not have any rehabilitation services for people who suffer from disabling conditions.
- The majority of successful rehabilitation and recovery services in Western Australia are in the metropolitan area and are run by non-government organisations wholly or in partnership with government services.
- The lack of services in Broome results in a significant financial

burden for taxpayers who fund transport for our clients down to Perth and back again under the Patient Assisted Travel Scheme, an unmanageable care burden on families of people with a mental illness and great pressure on our service to support people in the community without the appropriate resources.

- While approximately three quarters (75%) of people with serious mental illness are typically excluded from the workforce, the evidence is that the majority want to work and that they can work, that is, when evidence-based services are in place (Waghorn G 2009).
- Disability employment services in Australia are now achieving employment outcomes of 13 weeks or more employment for 10%-14% of people with a primary psychological or psychiatric disability (Australian Government 2011).
- Many students and young persons with mental health issues are not being identified, by schools, family members or peers.
- Job Capacity assessments are not appropriately identifying and referring individuals with mental health issues to available services. (indicative of the statistics for referalls in the East Kimberley, compared to statistics of people with mental health in the Kimberley)
- As diagnosis and referalls are not occurring, it is difficult to gage a need for services, resulting in areas with significant mental health populations wanting for services such as psychologists and DES agencies
- Psychologists are based in large regional centres, or come from Perth, and often spend 50% of their time travelling, rather than providing services. For example, mental health pschologists with the Allied health team spend 10 hours travelling return from Broome to Fitzroy Crossing every week, are funded to stay in hotels (due to accommodation shortages), and spend several more hours each week travelling between the many remote communities in the Fitzroy valley. Actual 'client contact' time is therefore minimal. 'Remote Servicing' also impacts of a service providers ability to develop repor with communities, as service providers are not viewed as 'locals', and are not readily available as needed.
- Schools are often serviced by 'visiting' psychologists, and often go for months without accessing a psychologist. Waiting lists for assessments can be over 12 months long, and consent regulations create huge barriers. Pschologists require informed consent prior to working with a minor. Informed consent requires locating and meeting with guardians. Often guardians do not have phones, are very difficult to locate, and may not speak English as

a first language, or have literacy barriers which create difficulties understanding required paper work. Given psychologists are often 'visiting' the likelihood of locating and receiving informed consent (required before working with any minor) can take months. Once consent is obtained it lasts only 6 months and is then required again.

- The 'wet season' prevents services from accessing large portions of Northern WA for at least 3 months each year. Whilst mental illness does not go away, these services do for large periods of time, greatly impacting on any 'recovery' or progress an individual may have made leading up to the wet season.
- Support for family members of individuals with mental ill health is wanting. EG. An individual recently required to identify the body of her son (a victim of suicide) was not offered any counseling, support or follow up. This individual soon developed depression herself, lost her job and is dealing with grief and loss, financial issues and isolation.
- JSA services have identified a large portion of their stream 4 referrals are individuals with mental ill health. Several of these agencies have reported they do not have the capacity or specialist knowledge to provide the intense support individuals need when they are experiencing an 'episode', and are only able to provide adequate support when these individuals are 'well'.
- Cultural approaches towards managing mental ill health are often not acknowledged in service provision (ie. diagnostic tools, assessment procedures are often inappropriate and fail to consider language barriers, cultural explanations of disability, holistic views of disability etc).
- Often General Practitioners and service providers do not acknowledge the importance of employment/ education in the 'recovery' process for individuals with mental ill health, so therapy and recovery plans fail to consider employment and education.
- Fear and stigma often prevent individuals from identifying ones self as having mental health illness, and this is acknowledged to be even greater for Aboriginals, who already suffer significant disparity in various areas including education and employment, due to their Aboriginality. Identifying or disclosing mental ill health would result in dual disadvantage (in the least) so is often avoided.

Ways to enhance access to and participation in education, training and employment

1. School staff require training and professional development to assist in identifying students with mental ill health
2. Parents, students and other service providers (ie. Education Assistance and mentors) require support and training to identify students, peers and family members with mental ill health
3. Services and Supports must incorporate and respect Aboriginal culture and traditions, and be assisted to implement protocols, policies and procedures that are culturally sensitive (including consideration of various language groups recognition and understanding of mental ill health)
4. Services must be implemented (or where existing assessed and amended) in direct and ongoing consultation with local communities. Consultation must be provided in a manner identified and approved by community members (including elders) to ensure all stakeholders are able to engage and partake in service development, design and delivery.
5. Families with members diagnosed with mental ill health require support, training and access to services to ensure families feel able to provide necessary and appropriate supports for their loved ones (and to prevent other members from developing mental ill health conditions)
6. Communities (including educational institutions) must be supported in a holistic manner to identify members with mental ill health in a non threatening manner, utilizing assessment tools which are culturally appropriate
7. Where needs are identified communities must be supported to have access to Disability Employment Services and rehabilitation services, which are locally based (where possible).

Suggested strategies

1. Establishment of Rehabilitation and Recovery services in Broome/Kimberley (Broome Networked Recovery Centre –BNRC) through a collaborative model with other mental health and community service providers. This project has begun and we have recently completed a refit of a building for this program to be based from after receiving a grant from the WA governments "Royalties for Regions" program. Further funding was obtained through the WA Mental Health Commission to establish this program for the first two years. This

happened after we were unsuccessful with our initial application through Department of Education, Employment and Workplace Relations. The BNRC will have broad criteria for admission and will be able to provide services to anyone who could benefit from our programs. We have estimated that there is a current demand of approximately 300 people in Broome who could benefit from one or more of the three streams of programs at the CNRC (clinical rehabilitation, social and recreational programs and supported employment program). This estimate is based on the following sources:

2. The Individual Placement and Support (IPS) is a new initiative between Disability Employment Providers (in our case Kimberley Personnel) and community mental health services. This new model and project is being sponsored through WAAMH and MHC.

The IPS evidence-based model has a proven record with employment outcomes for people with serious mental illness of 60% or more (Bond G 2004; Rinaldi M 2004; Waghorn G 2005; URBIS 2008; Lloyd C 2009). The IPS is a proven model of individualized mental health and employment service delivery. It promises a doubling of employment outcomes, with aligned recovery and social inclusion advantages.