

A Contributing Life

**the 2013
National
Report Card**

on Mental Health
and Suicide Prevention



Australian Government
National Mental Health Commission

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We also acknowledge our partners across the mental health sector who both supported us and participated in consultations, spoke with us at forums around the country and participated in our

Contributing Life Project surveys. We value the generosity of their time – whether it was to speak of their personal experiences, their achievements or to share their data and insights. Without their input it would not have been possible to produce this Report Card.

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Grateful thanks also go to the Mental Illness Fellowship of Australia, and the many other mental health support and advocacy organisations that supported the process to include the real experiences of people in this Report Card.

About us

This is the second annual Report Card of the National Mental Health Commission.

The Commissioners are: Mr Peter Bicknell, Ms Jackie Crowe, Professor Pat Dudgeon, Professor Allan Fels AO (Chair), Professor Ian Hickie AM, Mr Rob Knowles AO, Ms Robyn Kruk AM (retired July 2013), Ms Janet Meagher AM, Ms Sam Mostyn and Professor Ian Webster AO.

The Chair and Commissioners thank the Commission's staff for their outstanding efforts and commitment to their work and to the development of this Report Card.

Our vision: All people in Australia achieve the best possible mental health and wellbeing.

About this Report Card

This publication is the second of an annual series of the National Report Card on Mental Health and Suicide Prevention. This Report Card is accompanied by a technical document that provides detailed commentary on the data it contains, a supporting document that provides a detailed Report Back against our 2012 Recommendations and a set of literature reviews. These documents can be downloaded from our website www.mentalhealthcommission.gov.au

A number of electronic fact sheets along with a Report Card summary publication are available on our website. Please note that there is the potential for minor revisions of data in these reports; please refer to the online version for the most up-to-date version.

A complete list of the Commission's publications is available from our website.

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In 2013 we add a further eight recommendations to our existing ten from last year:

Recommendation 11:

People with co-existing mental health difficulties and substance use problems must be offered appropriate and closely co-ordinated assessment, response and follow-up for their problems.

Recommendation 12:

National, systematic and adequately funded early intervention approaches must remain. This must be accompanied by robust evaluation to support investment decisions, with a focus on implementation, outcomes and accountability.

Recommendation 13:

A National Mental Health Peer Workforce Development Framework must be created and implemented in all treatment and support settings. Progress must be measured against a national target for the employment and development of the peer workforce.

Recommendation 14:

A practical guide for the inclusion of families and support people in services must be developed and implemented, and this must include consideration of the services and supports that they need to be sustained in their role.

Recommendation 15:

The Commission calls for the implementation and ongoing evaluation of a sustained, multi-faceted national strategy for reducing discrimination.

Recommendation 16:

All Australians need access to alternative (and innovative) pathways through school, tertiary and vocational education and training.

Recommendation 17:

Where people with mental health difficulties, their families and supporters come into contact with the criminal justice system and forensic services, practices which promote a rights and recovery focus and which will reduce recidivism must be supported and expanded.

Recommendation 18:

Governments must sign up to national targets to reduce suicide and suicide attempts and make a plan to reach them. These targets must be based on detailed modelling.

Where the 2012 Report Card priorities took others

Our contributing life approach and reform priorities have been echoed by others in a range of initiatives this year. These are just some of the things we see as significant:

The new Australian Government has tasked us with conducting a **comprehensive review of the effectiveness of the current mental health system and outcomes**,⁷ a job we intend to take very seriously. This additional responsibility reaffirms and re-emphasises our cross-sectoral leadership approach. It will encompass a contributing life perspective.

The Australian Government established the Ministerial **Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group** in June 2013.⁸ This Group is welcomed by the Commission.

States and territories, agencies and experts came together to **publicly release national seclusion data** for the first time.

Two **new state mental health commissions** in New South Wales and Queensland were established.

Work by governments continued on **Consumer and Carer Experiences of Care survey tools**. Work was concluded on the development of a **National Mental Health Service Planning Framework** – a world first that will tell us the mix and level of mental health services and supports that people should get regardless of where they live, and the workforce and other resource needs. This work is done; the model needs to be tested in the real world and for all governments to sign up to it.

Our cautionary advice to avoid incentivising bed-focused services was heeded in planning for **Activity Based Funding** for mental health services. The advocacy of the Commission and others meant that psychosocial disability is being taken seriously in the **National Disability Insurance Scheme**. We continue to pay close attention to the design and implementation of these major initiatives.

After they were highlighted in last year's Report Card, the **physical health** needs of people living with mental illness received much attention, including through a National Summit hosted by the Australian and New South Wales governments.⁹ However, we are yet to see any tangible national policy action emerge from this.

The NSW Government soon after adopted the principles of the international Healthy Active Lives (HeAL) Declaration,¹⁰ which highlights the physical health challenges faced by young people with psychosis.

Highlights of our activities and successes since 2012



What is important to a contributing life

We regularly and systematically listened to people's experiences.

The National Contributing Life Project piloted a small population survey, undertook an online survey targeting people with lived experience, and held community conversations and focus groups. These have asked what barriers and enablers have most effect upon a person's ability to lead the type of life they want.¹ The early findings are reported throughout and have influenced this Report Card. The pilot will determine how the Commission conducts future regular national qualitative surveys. This way we will hardwire peoples' experiences into our reports and advice about what works and what needs to change.

Promoting mentally healthy workplaces

We were a catalyst for the establishment of the Mentally Healthy Workplace Alliance,

a national coalition of business, community and government leaders.¹ In 2012 we highlighted the importance of meaningful work and how employment opportunities for and the participation of people with lived experience and their supporters must be expanded. The Alliance has called for good practice examples that industry, small and large businesses and all employers can draw upon.² Together, members are developing practical resources for businesses to be released in early 2014. Like much of what the Commission has done in our first two years, this initiative builds on the work of many before us. But it takes a deliberately different approach in involving business owners and leaders to drive cultural change from the top.



Working to eliminate the use of seclusion and restraint

We established an independent National Seclusion and Restraint Project to look at good approaches nationally and overseas.³

In 2012 we called for real reductions in rates of seclusion and restraint because we know these practices are not therapeutic and not in line with human rights. We are working with others to reduce and eliminate these practices. Together we had a significant impact – for the first time state and territory governments publicly released national seclusion data in July 2013 and said they would do so every year.⁴ We understand that governments are agreeing a national definition of restraint to allow for this data to also be collected and reported. We urge that this work be given priority. We remain troubled by these practices and will remain vigilant.

Valuing lived experience and the expertise it brings

We implemented a Paid Participation Policy and developed a Participation and Engagement Framework.⁵ The Framework was written with expert input of the National Mental Health Consumer and Carer Forum. It transparently and clearly establishes our standards on how we recognise and work across all sectors. Both documents acknowledged the valuable contribution of others to our work.



Measuring success in a way that is meaningful to peoples' experience

Last year we called on governments to **be brave enough to set goals and targets for improving mental health and reducing suicide**, and to be judged by the community on their results. A few weeks later the Council of Australian Governments (COAG) asked our Chair, Professor Allan Fels, to lead a new Expert Reference Group to develop whole of life outcome targets and indicators to measure national progress. The elements of a contributing life were considered in this work and in September 2013 the group published and sent its independent advice to governments. This important work cannot go unheeded and we call upon governments and others to consider this advice and respond.

While these measures of success take a national, whole of population approach, the Commission is particularly concerned to see better outcomes for specific groups who carry a higher burden of mental health problems and suicide risk. Therefore, data to support each measure should at least be collected by: gender, age, Aboriginal and Torres Strait Islander descent, Culturally and Linguistically Diverse background, sexual orientation, and rural and remote location. The disaggregation of data will enable more detailed analysis of progress to ensure that targets are met across the population. In particular, the Commission will take advice from the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group on measures of success on the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples.

Above all, a unified and purposeful drive for reform must have a set of national targets to stimulate systemic and behavioural change. Governments and communities must set a destination and course for improved outcomes and experiences. Gains across all of life's domains must be meaningful and measurable.

Leading collaboration

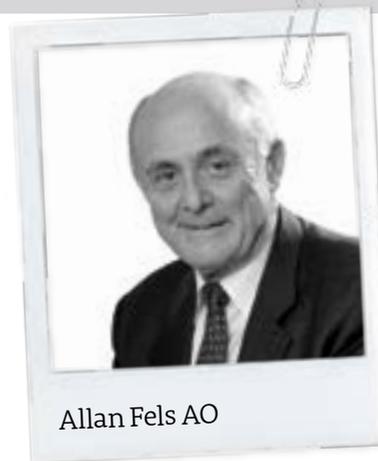
We forged strong relationships across Australia and overseas.

With the New South Wales Mental Health Commission, we hosted an international meeting of mental health commissions and experts in March 2013. The contributing life framework was supported and referenced in the resulting joint statement of commitment, the *Sydney Declaration*.⁶ We signed several Memoranda of Understanding, including with the National Mental Health Consumer and Carer Forum, Australian Human Rights Commission and Mental Health Commission of Canada and are developing one with state mental health commissions and the New Zealand Mental Health Commissioner.





To the Prime Minister of Australia



Allan Fels AO

Dear Prime Minister,

Mental health reform is a nation-building issue.

It is as fundamental to a better Australia as building new physical infrastructure, economic reform and social investment.

Mental health problems affect nearly half of all Australian adults at some point in their lifetime. Poor mental health has significant social, economic, productivity and participation impacts.

Indeed, during the election campaign you recognised that mental illness is the “hidden epidemic” in modern Australia.

You have many demands on your new Government. However, as an economist, and as a father of a daughter with an enduring mental illness, I can see the national, community, family and personal benefits from supporting people with mental health problems to have choice, opportunities and be included in all aspects of our society.

As you commence your Prime Ministership, **I write with two key messages** based on the National Mental Health Commission’s findings to date. I believe these require your personal leadership to secure the potential benefits:

Improving mental health is an invest-to-save issue. Tackling the causes rather than the symptoms; preventing mental illness and suicide in the first place; promoting good mental health for everyone; and timely support when things start to get tough, is the best economic and social renewal strategy that we can invest in.

Our current system is not designed with the needs of people and families at its core. These needs are wider than health services – they are about supporting recovery and leading a contributing life.

Other leaders and experts join me in writing to you with their insights.

Our National Review of Mental Health Services

I welcome your confidence in the Commission in making your Government’s election commitment to mental health reform, and giving us adequate resources to do so. We look forward to getting started on the review on behalf of the Australian community.

This will be an independent, comprehensive review of the effectiveness of the current mental health system. **We urge that it be guided by six fundamental principles.**

- 1. The review must have at its heart the needs and preferences of people who live with mental illness and those who support them, and be planned with them.** Our own National Contributing Life Project’s early findings¹¹ are that stigma and discrimination, economic, job and housing insecurity and poor social connections are the biggest barriers to a productive, fulfilling and healthy life. We need to identify the gaps in services and the systemic barriers which perpetuate disadvantage.
- 2. The review must take a whole-of-life perspective on mental health.** Supporting people to achieve their aspirations and potential is not just about providing excellent clinical mental health services. Having meaningful things to do, maintaining connections to community, family and culture, and having a stable place to live, are all intrinsic elements of a contributing life – none of which we can afford to ignore. The review needs to assess how services across sectors might be better integrated or co-ordinated to provide joined-up support.
- 3. The review must consider the ultimate indicator of service effectiveness to be whether it makes a positive difference to the ability of a person to live a contributing life.** All too often we focus on measuring cost-per-activity, but this is not the way to gauge value for money.
- 4. The review must consider the appropriateness of the current balance of investment.** This is heavily weighted towards acute care, resulting in a crisis-driven system. We do need sufficient hospital beds for when people need intensive clinical treatment, and not because community-based support has failed them. We need to move funds towards a system focused on prevention and early intervention. This doesn’t just make sense economically but – most importantly – it improves the chances of a contributing life for those who experience mental illness.
- 5. The review must build on Council of Australian Government (COAG) and tri-partisan support for mental health reform** and be characterised by strong engagement and consultation across governments and across sectors.
- 6. The review must not be rushed.** We take this task very seriously, and believe that meaningful reform can only be based on detailed consideration of the judiciousness, effectiveness and efficiency of current investments; the balance, targeting and distribution of this investment and current incentives; and the cost-benefits of different models in terms of both indirect and direct impacts on peoples’ lives. All of this will entail careful development of appropriate indicators of service quality and effectiveness – a task which is presently challenging jurisdictions all over the world.

The review will provide your Government with evidence upon which to make future policy and investment decisions. You can expect our recommendations to be clear and frank.

The case for review and reform is unambiguous.

While we contribute to ongoing mental health reform directions, we note your commitment to quarantine current funding for mental health, but also note that this level is already mismatched to the burden of disease, productivity loss and contribution to years of disability and life lost.

Governments spent an almost record \$6.9 billion (or \$309 per Australian) on specialist mental health services in 2010/11.¹² A recent study found that at \$28.6 billion per year (excluding capital), total direct expenditure on supporting people with a mental illness in Australia far exceeds that previously estimated and is equivalent to 2.2 per cent of Australia's Gross Domestic Product (GDP).¹³

Until it conducts the review the Commission is unable to tell you whether this investment is being spent to the best effect and on the supports that will have the greatest positive impact on people and families.

As significant as this investment is, it is not enough to truly alleviate the burden associated with mental illness. In Australia, the total mental health budget is itself only 6.5 per cent of the health budget when the total burden of disease due to mental illness suggests this should be closer to 14 per cent.¹⁴ Furthermore there are still questions unanswered about our level of investment in young minds – about 11 per cent of spending on specialised mental health services in 2010-11 was towards child and adolescent services¹⁵ yet 0-17 year-olds comprise almost 23 per cent of the population.¹⁶

These expenditure figures exclude indirect costs, such as lost productivity. Psychological distress in the workplace produces a \$5.9 billion reduction in employee productivity per annum.¹⁷ Each and every year, the societal costs of depression in the workforce are estimated at \$12.6 billion.¹⁸ Better health and education can result in substantially greater labour force participation for people living with a mental illness. Averting the impacts of that illness has a positive effect on workforce participation and increases the likelihood of working by between 25 and 30 per cent.¹⁹ The need for housing support is growing as is insecurity of accommodation. People need a stable place from which to recover and contribute.²⁰ Such benefits can be realised through better participation, removing barriers to employment, to facilitate full inclusion across the economy.

These are social investments with good rates of return.

On top of these persuasive figures, suicide takes the lives of 44 Australians on average each week – far greater than the number killed on our roads.²¹ Aboriginal and Torres Strait Islander peoples are two times more likely to die by suicide than non-Indigenous people.²² Suicide and suicidal behaviour has been estimated to cost Australia \$17.5 billion a year (in 2007-08 dollars), approximately 1.3 per cent of GDP.²³

Our second year in review

Our first Report Card on Mental Health and Suicide Prevention made ten recommendations, and they remain just as valid today as they were 12 months ago. This year we report back on these recommendations and we make a further eight.

In 2012 we highlighted four priority areas for ongoing action:

1. Mental health must be a high national priority for all governments and the community

While we have made good progress, mental health reform is far from complete. It remains the Commission's strongest view that mental health must stay on COAG's agenda and enjoy tri-partisan collaboration that extends beyond electoral cycles.

There is an opportunity to realise Australia's potential and progress. Your new Government's agenda to review the current system with your state and territory colleagues has the potential to fundamentally reshape the current arrangements to improve outcomes.

We can no longer afford to not have a proper understanding of the value of good mental health.

The economy is transitioning and the imperative to see mental health as a broader social and economic issue is more pressing than ever. Are we using our resources most effectively now? Are current governance, funding and delivery structures working for people and families? Are they enabling access to prevent problems and promote recovery? Short-termism and dodging responsibilities will only exacerbate our current situation and be costly to people, families and the taxpayer. Too many people are ending up in insecure homes, in the criminal justice system and in hospital beds because they are inadequately supported in the community.

2. We need to provide 'a complete picture' of what is happening and closely monitor and evaluate change

The Commission's contributing life framework has resonated with the community, the sector and employers. With a serious, long-term reform agenda we can give individuals and families the opportunities to develop and fulfil their potential, work creatively and productively, build strong relationships and contribute to the community and economy. In doing so, lived experience – either from a personal experience of mental health difficulties or from supporting someone else – must be central to design, implementation and evaluation.

Measuring success must centre upon people's experience of care, quality of life, and other determinants such as access to housing, education and meaningful employment and leading a life free from discrimination. It is not about measuring cost per activity. It is about measuring the extent to which interventions improve lives.

3. We need to agree on the best ways to encourage improvement and get better results

Implementing evidence-based models of support will help to close service gaps. Systemic evaluation must be a first thought, not an afterthought.

For example, we must see action on the poor physical health of people with mental health issues. People with severe mental illness die between 10 and 32 years earlier than the general population²⁴⁻²⁷, a life expectancy second only to Aboriginal and Torres Strait Islander peoples.²⁸

Further, as significant national initiatives such as the National Disability Insurance Scheme (NDIS) and Activity Based Funding are implemented, we will continue to pay close attention to their impacts on mental health outcomes.

The NDIS is a very welcome development and offers great hope, choice and control for some people living with severe and persistent mental illness, and those where early intervention has good potential to reduce the long-term burden of disability.

Yet there are concerns about the possibility that current spending on other mental health supports may be displaced to fund the scheme and that we may unintentionally close doors on some people. In relation to Activity Based Funding, it is essential that we do not forget about the urgent need to invest in community supports and not incentivise a hospital-centric model.

4. We need to analyse where the gaps and barriers are to achieving a contributing life and agree on Australia's direction

Finally, we must set a destination for reform and systematically and transparently measure and report progress and results, not more activity. In this Report Card I repeat our call from last year for COAG to sign on to ambitious national reform targets and indicators.

Soon after the 2012 Report Card was released I was asked to chair the independent Expert Reference Group established by COAG to develop targets and indicators for mental health reform. This group consulted widely to ensure the voices of people with lived experience were heard and translated into the measures. The group's recommended framework, based upon the principles of a contributing life, was publicly released and submitted to governments in September 2013. The Commission endorses its directions and urges COAG to respond.

In its first 18 months the Commission has also actively sought out and considered ways to measure how effectively investments in government, private and non-government services are making a difference. We remain convinced that, on the whole, as a country we are collecting the wrong data to measure real outcomes. We remain adamant that measures of success must take a whole of life and person- and family-centred approach. They must focus upon the levers that will drive the biggest systemic and behavioural change over time. We will use measures to report independently to the community, and build them into our review of the current system.

I am also pleased to hear that your Government will be a government for all people and will not leave anyone behind.

Your commitment to Aboriginal and Torres Strait Islander Australians is well known, and we welcome the formation of an Indigenous Advisory Council that will report directly to you. The establishment of the Ministerial Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group this year was a great step forward and has become a valued partner. This Group contributes strong leadership and expertise in social and emotional wellbeing, mental health and suicide prevention.

In our 2012 Report Card we highlighted the tragic lack of opportunities for good social and emotional wellbeing in our Aboriginal and Torres Strait Islander communities. We must measure and evaluate progress. Action on this is long overdue.

The disadvantage associated with mental ill-health and suicide risk extends into every corner of Australian society. No family and no community is immune. Pronounced income inequality in wealthy nations is associated with a higher prevalence of mental disorders, and socio-economic disadvantage drives an increased risk of developing a mental disorder.²⁹ Poor mental health is the leading cause of disability burden in our country.¹⁴ This burden inevitably increases in times of economic downturn.

A recent Productivity Commission working paper found that certain people continue to experience deep and persistent disadvantage and are being 'left behind', including people with enduring and disabling health issues. The paper highlights the complex interplay between, and compounding effects of, personal resilience, family circumstances, community support and the broader economic and social environment.³⁰

It is my view that your Government's plans for a prosperous future must include mental health reform as an integrated component. Mental health and wellbeing must be considered across all portfolios when developing social and economic policy and designing implementation.

The Commission's independence from individual departments and funding and program management is essential to its role of providing you and your government with unfettered advice that looks across all of the systems and supports that help people to live contributing lives.

Introducing our 2013 Report Card

As the National Mental Health Commission completes its second year, I present to you A Contributing Life: the 2013 National Report Card on Mental Health and Suicide Prevention.

This builds on our first Report Card, released one year ago to the day. It reflects the community's voice on the issues in mental health and suicide prevention that matter most to them.

This year the Commission visited communities and support services in Sydney, Canberra, Cairns, Yarrabah, Perth, Port Hedland, Hobart, Launceston and Melbourne. We continue to be impressed by the optimism and resilience of communities and the hard work and ingenuity displayed by many in the face of service gaps. The communities and workers at Yarrabah and at Port Hedland are testament to this. Disappointingly, we continue to hear of poor experiences, marginalisation and discrimination. We observe a concerning trend of services retreating from their roles and of governments retreating from their funding commitments to support people in the community. Again, this is poor economics.

This Report Card sits above the different views and vested interests that have too often led to disunity and competitiveness. These debates draw energy away from what the 7.3 million Australians who today have a lived experience of mental illness deserve. Australians deserve a reform plan with a clear destination and funding to match which is undertaken in a spirit of genuine co-operation. Some of them have joined with me in writing to you, and I ask that you consider their letters carefully.

With your leadership, through a whole of life approach that leverages drivers of inclusion, participation and productivity, and by putting 'mental wealth' at the centre of all policy making we are confident that we all can do better for those 7.3 million Australians and their families.

We cannot afford to not do so.

Yours sincerely

Professor Allan Fels AO

Chair

November 2013 Dear Prime Minister,

RichmondPRA
Together, we're better.



Dear Prime Minister,

Peer work is our personal choice and the strength and value of the peer workforce is evident in the achievements of those people we support. Whatever people might hope to achieve, peer workers provide inspiration and motivation to enable and encourage that hope.

Extracting from our own lived experiences, peer workers engage and mentor people to help them develop their own sense of mastery in their recovery efforts and personal challenges.

We understand each person's journey of recovery is in fact a journey of personal discovery and transformation. We know the dangers and pitfalls along the way and we provide empathetic support that only lived experience can offer.

Scars heal. We know this because we've been there and have learned a lot.

Peer workers don't teach or strategise. We listen.

Peer work is more than just another support worker position. It has clear duties and a real, ethical responsibility with tangible outcomes. It requires life experience and recovery journey practice. It requires discipline, self-esteem, self-belief, an awareness of triggers, faith in one's own strengths and wisdom to know one's limitations. It requires dedication and informed commitment to recovery philosophies.

I invite the Australian Government to consider including peer work as an essential component of all mental health services.

After all, Peer Workers are the champions of recovery.

Peter Farrugia

Peer Manager, Richmond PRA

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Dear Prime Minister,

Thirteen years ago I had reached a stage in my life where I thought my life was complete. I had two beautiful daughters, followed by my doting little boy, Justin. Suddenly all that changed. Justin, who was almost three years old, drowned in a neighbour's backyard pool. That same day I drowned with him!

That person (pre-tragedy) was never to be the same again. Instead, a changed person emerged. Through the helpful guidance and support of peers who had experienced the death of their child before me, I received the precious lifeline. They, through their own lived experience, showed me how other parents who had suffered the pain of grief were now living meaningful lives. It gave me the hope that I could too.

The reason I now work for The Compassionate Friends is to advocate and raise awareness of the value of peer support. Peer support can assist someone in a life crisis, at a point of vulnerability, to being active in one's life again. I recommend that everyone going through a crisis in their lives should have access to peer support.

Living well in bereavement is possible, although a scar and void in my life and family remains forever. And that's ok.

Kind Regards

Josie C



Dear Prime Minister,

ARE YOU LISTENING TO US?

Is our system UNWELL and not CONFORMING to our needs? As consumers and carers do we need to start a RISK ASSESSMENT on the system? As a person of lived experience that is employed in the mental health system I recognise the amazing work of individuals and organisations but I am also constantly reminded that our system needs much improvement. I work and connect with people, consumers and carers and I listen to the struggle and frustration of a system not listening to them.

Consumer and Carer participation needs to be improved. Consumers and carers must be encouraged to be involved in all functions of the mental health system. From Funding to service delivery we need to be respected, heard and represented in all areas of decision making. Only then can we call our system a well balanced system that supports recovery.

Yours sincerely,

Lindy B



Warren Talbot

Dear Prime Minister,

LGBTI people have the highest rates of suicidality of any population in Australia. Same-gender attracted Australians have up to 14 times higher rates of suicide attempts than their heterosexual peers. Rates are six times higher for same-gender attracted young people. Many Australian organisations report that they provide services for LGBTI people because they treat everyone the same. However, LGBTI people continue to be overrepresented in the suicide statistics.

There is a need to support prevention and early intervention programs that seek to address LGBTI mental health issues.

MindOut! is the first national project of its kind, working with LGBTI organisations and mainstream mental health organisations to improve mental health and suicide prevention outcomes for LGBTI people and populations.

The National LGBTI Alliance provides a combination of public workshops, resources, information and networking opportunities designed to increase understandings, capacity and ability to work with LGBTI people as a distinct culture with specific concerns and needs.

These measures are moving us toward providing LGBTI Australians with the same rights and services that other Australians enjoy.

It is now time to develop a National LGBTI Suicide Prevention Strategy.

Warren Talbot

General Manager of the LGBTI Health Alliance

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Jennifer A. Westacott

10 October 2013

The Hon Tony Abbott MP
Prime Minister
Federal House of Representatives
Parliament House
CANBERRA ACT 2600

Dear Prime Minister

To me and members of the Business Council of Australia, true wealth is not just measured by GDP. It is also about how a strong economy contributes to job creation, having first class health and education systems, decent infrastructure and proper opportunities for people. That includes people living with mental illness, their families, friends and other support people.

I think the whole point of growing our economy is to make sure that all Australians have the opportunity to work and have a better quality of life. This is fundamental to our economy, to social cohesion, to our sense of national wellbeing and our confidence as a country.

Increasingly, it will be people, ideas and innovation that underpin a successful Australian economy. So, in preparing for the future, the most important thing we can do is to put in place the systems and structures that encourage every individual to realise their potential.

I am proud of the contribution our companies make to the economy, the number of people they employ and the role they play in creating national wealth. I am excited by the fact that business is leading a process to create more mentally healthy workplaces. It's good for business, it's good for people and it's the right thing to do.

It's about giving all Australians the skills and education to maximise their capacity to participate, to be productive and to thrive in a modern workforce and workplace. Again, that includes people with mental illness, their families, friends and other support people.

I look forward to working with your government to build the kind of inclusive society we all wish to live in.

Yours sincerely

Jennifer A. Westacott
Chief Executive

Business Council of Australia
ABN 75 008 483 216



Sheree Vertigan

Dear Prime Minister,

Educators must minimise the barriers that exist for students. Increasingly, schools are confronted by the issues associated with the deteriorating health and wellbeing of some students: and although this may be more pronounced in lower socio-economic communities it is a concern for all schools. The increase in students with a disability or mental health concerns has challenged schools to look beyond traditional education solutions to alternative and innovative responses.

Inclusion is a whole-school, whole-of-community response to removing learning barriers. Schools must reach beyond the boundary to find partners to provide support or opportunities so that students remain connected to education and transition to further education or training. Many schools use a full service model or multi-disciplinary support teams which may include school counsellors, welfare workers, youth workers, career or transition officers, chaplain, school nurse and community liaison officers. Communities cannot bear the cost of disengaged and disconnected youth and the best provision of service and support occurs when the school develops partnerships with community organisations and providers.

Schools are focused on improving retention and participation rates but this often means a reconceptualisation of school provision, increased personalisation and increased awareness of the student's needs. Highly successful inclusive schools build strong connections with the home, identify the barriers, intervene where necessary and continually evaluate progress. One size does not fit all; not all students are focused on an ATAR score but all students can have a plan, a pathway to the future that values both vocational and academic pursuits and keeps students engaged in education and training.

As school engagement with the community increases, and the focus on the importance of education spreads into the broader community, we are able to provide more hope, more support and more opportunities for young citizens.

Programs like Work Inspirations, School-based apprenticeships, project-based learning and internships, philanthropic initiatives, as well as increased awareness of mental health issues and the increased support that is available in some communities all contribute to the general wellbeing of the community and all help to create a better future.

Sheree Vertigan

President, Australian Secondary Principals Association



Sebastian Robertson

Dear Prime Minister,

For too long young people haven't been engaged in the discussion and development of the issues surrounding mental health. As suicide is the leading cause of death for young Australians it is concerning that we are facing a situation where the 'solution will be found for you, not with you'. It is time to give young people a seat at the table. Let them show you that they can indeed be a part of the solution, not the problem.

Over the past three years, starting when I was 25, I embarked on a journey to do exactly that – to give young people a voice – by founding Batyr. At Batyr we engage, educate and empower young people by speaking with them about social and mental health issues. It is a journey built on vulnerability, personal experiences and 'hope' that so many young people have lost on their journey. However, this has not been a lonely journey; it is and continues to be built and driven by young people; young people willing and eager to engage in conversations to help friends, family members and themselves. It is about empowering young people to stand up and share their lived experiences in the hope that by sharing their journey of recovery other young people may reach out for support when in need.

I fully support any report that highlights an increased need to engage young people in finding the solution around mental health.

It's time to talk. It's time for change, positive change.

I would appreciate any opportunity for young people to discuss with your office, how we can play a role in helping to find the solution to tackle these important mental health challenges.

Warm regards,

Sebastian Robertson

Founder & CEO
Batyr

Reporting back and looking forward

Introduction

Our second Report Card continues the National Mental Health Commission's commitment for change, building upon the foundations and whole of life scope established in our inaugural Report Card, *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention*,³¹ released exactly 12 months ago.

About the Commission

We are Australia's first National Mental Health Commission, set up in 2012 to provide independent reports and advice to the community and government on what's working and what's not.

From day one the Commission's view has been that we must think differently about mental health, to see mental wellbeing as important to the individual, their family, support people and community. This sees services not as separate elements to be used when needed. It sees that the interconnections between services, families, employers and co-workers, health providers, teachers and friends, together improve mental wellbeing and a sense of a life well lived.

Indeed, one of our strengths since inception has been our determination to take a whole of life, whole of government perspective to mental health, rather than treating it simply as a health issue. Despite the Commission no longer reporting to the new Prime Minister after the 2013 federal election, we will continue to take this approach. We look forward to working with the new Minister for Mental Health and his Cabinet colleagues to ensure that mental health reform does not drop in priority on the political, social and economic agenda.

We know that every family and community has an experience to share because mental health

difficulties will affect every Australian at some point, either personally or through the experience of friends, family or work colleagues.

We highlighted the scandal that the most severely mentally ill die at a rate that is two and a half times greater than the general population;³² and the shaming fact that Aboriginal and Torres Strait Islander peoples are twice as likely to die by suicide than other Australians.²¹

We were aghast that we still had no national picture of the extent to which we seclude and restrain people with mental health problems – a human rights issue that governments had, seven years beforehand, committed to reduce and eliminate.



A Contributing Life

We set ourselves, governments and the community a pressing task – to better understand and listen to what it means for people living with mental health difficulties and their support people to lead a *contributing life* – and to regularly and systematically listen to their experiences.

A contributing life means a fulfilling life enriched with close connections to family and friends, and experiencing good health and wellbeing to allow those connections to be enjoyed. It means having something to do each day that provides meaning and purpose, whether this is a job, supporting others or volunteering. It means having a home and being free from financial stress and uncertainty.³¹

The contributing life approach propels everything we do; it shapes the structure of the Report Card and its six chapters and frames how we work:

- we put people with lived experience and their families and supporters at the centre and always first
- we work across all areas that promote mental health and prevent mental illness and suicide – not just government and not just health but education, housing, employment, human services and social support
- we consider evidence and data, develop projects, seek new partners and report back to the community through this lens.

Our Contributing Life surveys and listening to people's stories wherever we go help us to cast a light on what needs to change, and where there are gaps in quality, service and access. People's experiences, voices and views allow us to more clearly see the data and will always be reflected in our work.

Our four priority areas

In 2012 we set out our big picture case for change; **four priority areas for action** that we must all do and keep doing.

We will not see real change unless these become part of everyday business. In 2013 these four priorities remained as drivers behind the Commission's work:

1 Mental health must be a high national priority for all governments and the community

- Mental health must be the business of the Prime Minister, Premiers and Chief Ministers
- We must get a proper understanding of the value of good mental health to drive reform
- Governments must meet their existing commitments
- The mental health and wellbeing of Aboriginal and Torres Strait Islander peoples needs to be included as one of our national priorities

2 We need to provide 'a complete picture' of what is happening and closely monitor and evaluate change

- Data must be rationalised and the right data collected
- The Australian Government needs to commit to conducting reliable and regular national population surveys to measure progress
- Governments must ensure that announced mental health funding is spent on mental health as promised

3 We need to agree on the best ways to encourage improvements and get better results

- We must initially agree on what is good practice across all mental health and support services. This must be based on evidence. Services need to be effective, efficient, provide value and demonstrate improvement in the mental health and experiences of people using them and their families and support people
- The new Activity Based Funding system should be designed to meet the needs of people with mental health difficulties regardless of whether services are provided in hospitals, in the community or elsewhere. Alternatives to hospital care must be a priority
- The National Disability Insurance Scheme must fully cover the psychosocial disability that results from mental illness

4 We need to analyse where the gaps and barriers are to achieving a contributing life and agree on Australia's direction

- All governments must prioritise the development and implementation of a nationally agreed mental health service planning framework
- Governments must be brave enough to set goals and targets for improving mental health and reducing suicide and be judged by the community on their results

We re-state here that in 2013 we want to hold up a mirror for all Australians to see what mental health services and supports are available and how effective they are in supporting people to achieve a contributing life.

As the new reporting arrangements for the Commission take effect, it will be critical to our agenda to influence and have impact across all relevant agencies and policy areas. A return to a single health policy focus will jeopardise the important initiatives previously recommended by the Commission. The Commission's strengths lie in its independence and being an agent for change across all elements of a contributing life. This must continue if we are to truly hold up a mirror to the mental health system in Australia.

Before we can assess how supports and services are successful or effective, Australia must first establish a clear destination, targets to drive change and how we measure progress in getting there.

In this Report Card we endorse the directions of the COAG Expert Reference Group which was asked to provide independent advice on a new set of whole of life outcome targets and indicators.³³ The Group consulted widely, found areas of consensus and recommended a framework of national targets and indicators to governments in September 2013.

This framework captures many of the Commission's own priorities and the areas that we believe will drive change – in

more people reporting better wellbeing; in improving life expectancy and physical health; in more timely access to care and treatment and safe, stable and secure homes; in improvements in the experiences people and families have; in increased employment rates for people and supporters; in working to eliminate the use of seclusion and restraint; in reducing suicide and suicide attempt rates.

It reflects the community's aspirations and the views of experts, including people with lived experience of mental health difficulties and their supporters. We urge governments to consider this work and respond.

Reporting back

Where the 2012 Report Card priorities took us

Building upon the base established last year, our work in 2013 has been two-fold.

Firstly we have concentrated effort in working on the actions to which we committed in the 2012 Report Card, as well as in raising awareness of our findings and encouraging work by others.

Secondly we have focused on what we would say in the 2013 Report Card – through listening to people with lived experience, establishing our new priorities, talking with a range of stakeholders and experts, visiting services, reviewing evidence and data, as well as commissioning literature reviews.

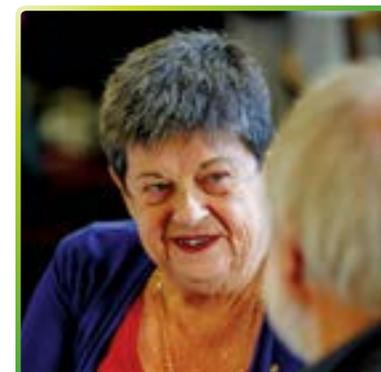
We report back on what has happened this past 12 months and assess what that progress looked like.

The elements of a contributing life were well received, especially by people with lived experience of mental health issues and their families and support people.¹

We were told that our strategy of putting the voices of people with lived experience to the front and centre of what we do is the most important aspect of

our national leadership and reporting role.

Our contributing life approach has influenced national and local debate and policy thinking. Some non-government organisations and even a corporate foundation have used our work to support their advocacy efforts and in their development of policies and position statements.



Reporting back on the 2012 Report Card recommendations

In 2012 the Commission set out ten clear recommendations for governments and others to consider and accept.

We promised to detail responses to our 2012 recommendations in this year's Report Card.

We are heartened by the actions taken by the non-government sector, business sector and first responders such as police.

We are disappointed in the lacklustre response from governments to the Report Card as a whole, but are encouraged by positive steps towards addressing some specific recommendations.

We are concerned that while separate initiatives were advanced in some key areas, in others nothing could be discerned.

So, what happened across the nation?

In giving a national assessment, the Commission wrestled with how to best identify those agencies, services or jurisdictions where change was evident; where people reported that their experiences had improved.

But to be frank – we could not find enough information to paint this picture.

Although we realise that it has only been twelve months, there is no excuse for not having made a start.

We were pleased to see that projects already initiated by governments and agencies continued and reached some success. But we still heard of services being closed, wound back or funds diverted.

In December 2012 COAG – the then Prime Minister, Premiers and Chief Ministers – welcomed the 2012 Report Card,

said they would jointly respond to it and that their response would include national indicators and targets for mental health reform.

At the time of writing, no COAG response has been received.

The Commission therefore invited all governments to provide individual responses. These were gratefully received from Western Australia, the Northern Territory and Victoria. The Commonwealth, Tasmania, South Australia and the ACT declined to provide separate reports. Responses from New South Wales and Queensland had not been received at the time of writing.

The following table represents our best endeavours to find and report information from the public domain as at October 2013. A more detailed 'report back' is available on our website.

Recommendation 1

Nothing about us, without us – there must be a regular independent survey of people's experiences of and access to all mental health services to drive real improvement.

How we see progress:

The Commission is HEARTENED but commitment to action by governments remains outstanding

Action called for: The National Mental Health Commission will undertake a regular national survey of people with mental health difficulties and their families and support people. This survey will consider access to services, as well as perceptions and experiences. This will build on and complement existing efforts and ensure that people always have a voice and remain at the centre of decision-making about all the services that impact on them.

What action could we see nationally?:

- While work is underway on national consumer and carer experiences of care tools, governments still need to commit to implement national tools to survey people's experiences.
- Individual pieces of work are underway – but a co-ordinated and systematic approach is yet to be established.
- The Victorian and Western Australian governments have made particular efforts to engage people with lived experience in policy and service design, such as the Victorian Consumer and Carer partnerships and initiatives to prioritise women's safety in in-patient units.

Our action:

- We piloted several methods to understand how best to obtain people's views on what is important to achieving a contributing life. The findings of this pilot *National Contributing Life Project* will become a regular national qualitative survey.
- We developed, released and implemented a Paid Participation Policy to establish the 'ground rules' for engaging the expertise and advice of people with lived experience.
- We launched our Participation and Engagement Framework in September 2013 that will guide our activities and ensure diverse and genuine engagement and participation.

Recommendation 2

Increase access to timely and appropriate mental health services and support from 6–8 per cent to 12 per cent of the Australian population.

How we see progress:

The Commission is DISAPPOINTED about the lack of leadership by our governments

Action called for: All governments must agree and meet the target in the Fourth National Mental Health Plan Measurement Strategy that 12 per cent of the population should be able to access mental health services in a year.³⁴ There must be an agreement to this indicator with an implementation plan and investment strategy to achieve this.

What action could we see nationally?:

- Current reported service treatment rates do not report upon timeliness or appropriateness of care.
- We understand that access to mental health services may be being considered as a performance indicator for reporting under the National Healthcare Agreement performance framework. But no clear action or statement as to a national unified strategy to increase access could be found.

Our action:

- The incoming Australian Government has given the Commission the task of undertaking a review of the mental health system, to identify where gaps and barriers are, and to see if money is spent effectively, efficiently and for the best outcome. This review will also include consideration of timely access to mental health supports across the population and lifespan.

Recommendation 3

Reduce the use of involuntary practices and work to eliminate seclusion and restraint.

How we see progress:

The Commission is HEARTENED by the co-operative approach across the country to openly report public service seclusion rates as a first step But the Commission is DISAPPOINTED that we remain distant from our target to end the use of seclusion and restraint and will continue to push for action

Action called for: All jurisdictions must contribute to a national data collection to provide comparison across states and territories, with public reporting on all involuntary treatments, seclusions and restraints each year from 2013. This information should be reported at the service unit level.

Action called for: The National Mental Health Commission will call for evidence of best practice in reducing and eliminating seclusion and restraint and help identify good practice treatment approaches. We will do this in partnership with the Mental Health Commission of Canada and Australian partners, including the Safety and Quality Partnership Standing Committee, Disability Discrimination Commissioner, Australian Human Rights Commission and interested state mental health commissions.

What action could we see nationally?:

- Significant first steps were seen: all states and territories for the first time publicly released national seclusion data and made a commitment to ongoing national data collection and reporting.
- Real and sustained national action on the apparent decline in seclusion rates is awaited, particularly given the wide variation of rates.
- Governments are developing a consistent definition of restraint, and we urge that this is given priority so data can also be publicly reported in a comparable way.
- The United Nations Committee on the Rights of Persons with Disabilities raised concern in October 2013 about restrictive practices and recommended that Australia take immediate steps to end such practices.

Our action:

- We established a National Seclusion and Restraint project in partnership with the Mental Health Commission of Canada, the Safety and Quality Partnership Standing Committee, Disability Discrimination Commissioner of the Australian Human Rights Commission and the involvement of state mental health commissions. The findings will be reported in 2014.
- A Core Reference Group of people with lived experience of mental illness and their families/supporters, academics, lawyers, human rights advocates, mental health professionals and first responders has been established to inform the project.

Recommendation 4

All governments must set targets and work together to reduce early death and improve the physical health of people with mental illness.

How we see progress:

The Commission was ENCOURAGED by governments' commitment to develop national targets and indicators for mental health reform

The Commission is DISAPPOINTED that while targets have been developed and submitted there is no commitment yet to adopt them

Action called for: Enduring mental illness must be given the status of a chronic disease to give it higher national focus and support.

Action called for: The physical health needs of people with mental health problems need to be given a higher priority in all areas of health. The initial focus must be on rapidly reducing cardiovascular disease by reducing risk factors such as smoking and poor diet, and by increasing physical activity for people living with mental health problems.

Action called for: All government-funded mental health related programs must also be measured on how they support people to achieve better physical health and longer lives. Priority should be given to the financing of multi-disciplinary primary care (through GPs and other primary health care organisations).

Action called for: All relevant services must give priority to tracking of both the physical and mental health needs of those with enduring mental illness.

What action could we see nationally?:

- No action on inclusion in chronic disease framework; however, psychosocial disability is now part of the National Disability Insurance Scheme (NDIS).
- A number of national initiatives that could provide opportunities for multi-disciplinary co-ordinated care have been started, including the NDIS, Medicare Locals and Partners in Recovery. These need to be rolled out in an integrated and careful way, with outcomes measured and reported.
- While physical health needs have been discussed by experts and state governments, including at a national summit in May 2013, there is no known progress from public reporting.
- NSW signed up to the principles of the Healthy Active Lives (HeAL) Declaration.

Our action:

- The Commission's view is that national measures of success must include improving life expectancy and physical health.
- The 2013 Report Card endorses the directions in the COAG Expert Reference Group's framework of national targets and indicators for mental health reform, which was submitted to governments in September 2013. This nominates measures to improve life expectancy and physical health, including addressing reductions in cardiovascular disease and smoking.

Recommendation 5

Include the mental health of Aboriginal and Torres Strait Islander peoples in 'Closing the Gap' targets to reduce early deaths and improve wellbeing.

How we see progress:

The Commission is DISAPPOINTED in the lost opportunity to include a mental health 'Closing the Gap' target

Action called for: Mental health must be included as an additional target in the COAG 'Closing the Gap' program. This must be done through the development and implementation of an Aboriginal and Torres Strait Islander Mental and Social and Emotional Wellbeing Plan to commence in 2013. This must also address the future findings of the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group.

Action called for: Training and employment of Aboriginal and Torres Strait Islander peoples in mental health services must increase. There must also be better support for Aboriginal and Torres Strait Islander families. There must be regular reporting on progress.

What action could we see nationally?:

- No action seen to date, noting that additional 'Closing the Gap' targets were added in 2013 but these did not relate to social and emotional wellbeing, mental health or suicide prevention.
- A National Aboriginal and Torres Strait Islander Suicide Prevention Strategy was released in May 2013.
- No evidence available publicly to measure increased training and employment of Aboriginal and Torres Strait Islander peoples in mental health services. Progress is noted through the expansion of the National Empowerment Project which shows promise for better support of families.

Our action:

- We contributed to the development of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.
- A Memorandum of Understanding was signed in August 2013 between the Commission and the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group, to seek and action opportunities for joint effort and collaboration.
- The *Sydney Declaration*, signed in March 2013 by international and national and state mental health commissions, identifies Indigenous mental health as one of five priority areas for collaborative effort and information exchange. It also commits to the Whararata Declaration.

Recommendation 6

There must be the same national commitment to safety and quality of care for mental health services as there is for general health services.

How we see progress:

The Commission is HEARTENED by the work underway to look at uptake of the standards, but there is still so much we don't know. We will continue to press for a national commitment to improved quality of care

Action called for: All governments must agree that there is the same emphasis on improving the quality of care and reducing adverse events in mental health services as applies to other physical health services. Governments must commit to implement nationally agreed and mandatory service standards in mental health services as they have for other health services. The National Mental Health Commission will work with the Australian Commission on Safety and Quality in Health Care to identify what it takes to get proper uptake of national mental health service standards and make them mandatory.

What action could we see nationally?:

- No COAG response received to date on a national commitment to improved quality of care and reduction of adverse events.

Our action:

- We have partnered with the Australian Commission on Safety and Quality in Health Care to establish the level of adoption of the National Mental Health Standards by services, their usefulness and utility.

Recommendation 7

Invest in healthy families and communities to increase resilience and reduce the longer-term need for crisis services.

How we see progress:

The Commission is DISAPPOINTED, while individual projects have been rolled out, there is no clear way to see or measure a national approach

Action called for: Increase enhanced and personalised support for parenting through culturally relevant forms of home based visiting (ante-natal and in the first few years of life). These must be provided at a local or regional level. There must also be active follow-up where a family is under stress or experiencing tough financial or social difficulties.

What action could we see nationally?:

- No COAG response to the 2012 Report Card received; no national priority, focus or co-ordinated drive in the antenatal period and in first few years of life is known from public information.
- Victoria's new Services Connect initiative aims to connect all human services for people and families.

Our action:

- We have started to find out what is useful to families to build their resilience through the pilot *National Contributing Life Project*.
- We commissioned and released a report into what young people want and need to support their mental health.
- We have listened to and heard the stories of hundreds of individuals and families at Commission meetings across Australia about what they think needs to change to improve their life.

Recommendation 8

Increase the levels of participation of people with mental health difficulties in employment in Australia to match best international levels.

How we see progress:

The Commission is ENCOURAGED by the leadership shown by business

The Commission is ENCOURAGED by actions that will result in a stronger peer workforce if taken up

The Commission remains DISAPPOINTED about the lack of progress to improve current employment systems for people with complex needs

Action called for: The National Mental Health Commission will pull together a taskforce, including industry, government and community leaders to actively promote effective government and workplace programs that increase the participation of people with mental health difficulties in employment. The Commission will partner with key industry and community groups to call for evidence and work together to advance the adoption of good practice in Australia.

Action called for: Employment support programs, initiatives and benefits must be more flexible. They must recognise that mental illness comes and goes and what that means for people and their families. Programs must provide long-term support for the employee, families and support people and the employer, with appropriate incentives and milestones.

What action could we see nationally?:

- No public evidence identified of more flexible national employment support programs, initiatives and benefits.
- Health Workforce Australia has undertaken a study into the peer workforce in Australia. The Commission has advised the project.

Our action:

- The Mentally Healthy Workplace Alliance was formed in 2012 and formally launched in July 2013. Firstly undertaking a call for evidence, the Alliance will turn its attention to participation/employment rates, building upon a foundation of evidence, evaluation and best practice.
- In August 2013, with the Australian National Council on Drugs and others, we advocated for Job Services Australia to work more effectively for people experiencing mental health issues, drug and alcohol problems and/or homelessness.
- We have funded Community Mental Health Australia to produce national training and development materials to support the Certificate IV in Peer Work.

Recommendation 9

No-one should be discharged from hospitals, custodial care, mental health or drug and alcohol related treatment services into homelessness. Access to stable and safe places to live must increase.

How we see progress:

The Commission is HEARTENED that new programs have been initiated, but will await their evaluation to assess impacts upon reducing homelessness

The Commission is DISAPPOINTED that while this has been a national commitment since 2008, we still have no public reporting of exits into homelessness

Action called for: All governments implement and report regularly on the existing COAG commitment of 'no exits into homelessness' from statutory, custodial care and hospital, mental health and drug and alcohol services for those at risk of homelessness.

Action called for: Discharge planning must consider whether someone has a safe and stable place to live. Data must also be collected on housing status at point of discharge and reported on three months later, linked to the discharge plan.

Action called for: Governments must commit to removing any structural discrimination barriers to accessing housing. Just as important is providing support to help vulnerable residents to settle in, adjust and remain in their homes.

What action could we see nationally?:

- Programs were initiated in the majority of states and territories.
- No evidence that governments have implemented or have plans to report regularly on their existing COAG commitment of 'no exits into homelessness'.
- No public evidence found on improved discharge planning.
- Some positive discrimination initiatives seen, but not widespread.

Our action:

- Our view is that national measures of success must include people having ensured access to safe, stable and secure homes.
- The Expert Reference Group's framework includes national targets and indicators in this area.

Recommendation 10

Prevent and reduce suicides, and support those who attempt suicide through timely local responses and reporting.

How we see progress:

The Commission is ENCOURAGED by the number and range of initiatives in this area, with more to be done

Action called for: Develop local, integrated and more timely suicide and at-risk reporting and responses. Developing and rolling out well co-ordinated community-based, culturally appropriate, early response systems and suicide prevention programs which promote community safety, reach the most vulnerable, and using up-to-date information from the 'first responders' such as police officers, occupational health workers, ambulance officers and mental health workers.

Action called for: Programs with a proven track record (which are evidence-based) must be supported and implemented as a priority in regions and communities with the highest suicide or attempted suicide rates – action needs commitment and a humane approach.

What action could we see nationally?:

- Turning Point Alcohol and Drug Centre is being funded to pilot a surveillance system for overdose and suicidal behaviour in Victoria, NSW, Queensland, ACT and Tasmania. This uses ambulance call-out data to distinguish patterns in suicides and suicide attempts, including across sub-populations or geographic regions. This project could shed light on these issues, help timely responses and contribute to national reporting. Sharing of results would help with policy and planning.
- Several new initiatives started by states and territories.
- Mix of evidence-based programs implemented, with others yet to be evaluated. More work remains.

Our action:

- We have commissioned the Centre for Research Excellence in Suicide Prevention to undertake a 12-month project on people's experiences of suicide attempts. This will start to gain a better insight to people's experiences in the lead-up to and after a suicide attempt, and what helped and what hindered.
- Our view is that national measures of success must include reducing suicide rates and the number of suicide attempts.
- The proposed national targets and indicators for mental health reform submitted to governments by the Expert Reference Group include addressing the national suicide rates and suicide attempts. We expand on this in Recommendation 18 in this Report Card.

We have held up a mirror and seen that much good work is underway. But we also see that we are getting further behind each year.

Lives continue to be lost to suicide.

People continue to be discharged to homelessness.

Crisis services continue to provide the only option when prevention and intervening early would be better for everyone.

Looking forward

Our direction in 2013

Across our range of conversations this year, the importance of prevention and early intervention was emphasised again and again.

We also heard that there are opportune times for intervention across all ages and throughout a person's recovery journey.

This makes sense economically and socially, where burdens from illness or consequent disability are lifted from individuals, families, employers, schools and communities.

We continued to hear that services and agencies need to work together for the person, focused on the whole person, working with the person and their supporters; that families want to be that – supportive families, not care co-ordinators.

The themes of the 2013 Report Card

In 2013 the Commission remains focused upon seizing opportunities for people living with a mental health difficulty and their families and supporters to lead a contributing life.

This year we investigate and spotlight new issues for close scrutiny and action.

Many people who have experience of poor mental health – which, after all, is half of the people we know – have also encountered some barrier to living the life they would like.

We shine a light upon the lives of the most disadvantaged people in our communities. This can be through economic or social circumstances and because of the impacts of their mental illness.

The highest barriers are often faced by:

- people with mental illness in prisons and ex-prisoners
- young people in juvenile justice systems
- people struggling with mental illness and difficulties with drug and alcohol use.

Discrimination just adds to their exclusion.

Not intervening early cements their disadvantage.

The case for investing early

Promotion and prevention must be priorities. They make sense.

Impacts from mental health difficulties faced by children and young people are substantial for them, their families and society – in under-achievement in education, early contact with the justice system and future employment.

Promoting resilient, mentally healthy communities, and preventing people becoming unwell or disconnected, are key to investing early in families and children.

A staggering fourteen per cent of Australia's children and young people have a mental health problem.³⁵ About fifty per cent of mental health problems emerge by the mid-teens, and around 75 per cent by age 25.³⁶ Earlier onset is associated with longer duration of untreated illness, and poorer lifetime health outcomes.^{37,38}

Only 25 per cent of young people with mental health problems receive treatment of any kind – and only 15 per cent of boys and young men. Young people living with mental illness are less likely than their classmates to complete secondary or tertiary education.³⁹ Suicide is the leading cause of death among our young people.²¹

It doesn't have to be this way. We can work to lift this weight from young people and their families.

The key is investment in prevention and intervening early for new parents, all families and young people. There is substantial evidence of what works both in terms of prevention and support – it is simply a case of putting it as a first priority.

The Commission called for this in our first Report Card, and again in 2013 we are calling our new federal Government and states and territories to commit to the task.

This cannot be subject to the short-termism of election cycles. It requires sustained vision and commitment. To fail to invest in children and young people's mental health is to fail them.

To fail to invest across the lifespan is to fail everyone.

We believe that timely interventions must be available when a person's mental health difficulty is emerging for the first time or re-emerging during the person's recovery journey.

All of the factors that can lead to or deny a contributing life do not exist or operate in isolation. They are part of an everyday life, and are affected by the transitions and changes we meet along the way.

Our 2013 recommendations

In 2012 we made **ten recommendations** for action. Since then 3.2 million Australians have experienced a mental health problem and at least another 2,200 people have died by suicide.

So these recommendations remain just as valid this year as they were last year. We re-state them here.

In 2013 we add a **further eight** for action.

We will re-visit all recommendations every year until we have evidence of change that can be seen in the lives of people living with mental health problems and their supporters.

Our recommendations are stepping stones towards a vision that all people in Australia achieve the best possible mental health and wellbeing.

We want to see healthier people, fewer people institutionalised in our prisons, less disadvantage and stronger Aboriginal and Torres Strait Islander communities. We want our young people to have a contributing future; families to thrive; a society that does not discriminate on the grounds of mental illness, race, disability or sexual preference. We want strong resilient mentally healthy communities, schools and workplaces.

Next year we hope we can give a positive report back on how these recommendations were addressed by us, our governments and service and support providers.

2012

Recommendations

Recommendation 1:

Nothing about us, without us – there must be a regular independent survey of people’s experiences of and access to all mental health services to drive real improvement.

Action: The National Mental Health Commission will undertake a regular national survey of people with mental health difficulties and their families and support people. This survey will consider access to services, as well as perceptions and experiences. This will build on and complement existing efforts and ensure that people always have a voice and remain at the centre of decision-making about all the services that impact on them.

Recommendation 2:

Increase access to timely and appropriate mental health services and support from 6-8 per cent to 12 per cent of the Australian population.

Action: All governments must agree and meet the target in the Fourth National Mental Health Plan Measurement Strategy that 12 per cent of the population should be able to access mental health services in a year. There must be an agreement to this indicator with an implementation plan and investment strategy to achieve this.

Recommendation 3:

Reduce the use of involuntary practices and work to eliminate seclusion and restraint.

Action: All jurisdictions must contribute to a national data collection to provide comparison across states and territories, with public reporting on all involuntary treatments, seclusions and restraints each year from 2013. This information should be reported at the service unit level.

Action: The National Mental Health Commission will call for evidence of best practice in reducing and eliminating seclusion and restraint and help identify good practice treatment approaches. We will do this in partnership with the Mental Health Commission of Canada and Australian partners, including the Safety and Quality Partnership Standing Committee, Disability Discrimination Commissioner, Australian Human Rights Commission and interested state mental health commissions.

Recommendation 4:

All governments must set targets and work together to reduce early death and improve the physical health of people with mental illness.

Action: Enduring mental illness must be given the status of a chronic disease to give it higher national focus and support.

Action: The physical health needs of people with mental health problems need to be given a higher priority in all areas of health. The initial focus must be on rapidly reducing cardiovascular disease by reducing risk factors such as smoking and poor diet, and by increasing physical activity for people living with mental health problems.

Action: All government-funded mental health related programs must also be measured on how they support people to achieve better physical health and longer lives. Priority should be given to the financing of multi-disciplinary primary care (through GPs and other primary health care organisations).

Action: All relevant services must give priority to tracking of both the physical and mental health needs of those with enduring mental illness.

Recommendation 5:

Include the mental health of Aboriginal and Torres Strait Islander peoples in 'Closing the Gap' targets to reduce early deaths and improve wellbeing.

Action: Mental health must be included as an additional target in the COAG 'Closing the Gap' program. This must be done through the development and implementation of an Aboriginal and Torres Strait Islander Mental and Social and Emotional Wellbeing Plan to commence in 2013. This must also address the future findings of the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group.

Action: Training and employment of Aboriginal and Torres Strait Islander peoples in mental health services must increase. There must also be better support for Aboriginal and Torres Strait Islander families. There must be regular reporting on progress.

Recommendation 6:

There must be the same national commitment to safety and quality of care for mental health services as there is for general health services.

Action: All governments must agree that there is the same emphasis on improving the quality of care and reducing adverse events in mental health services as applies to other physical health services. Governments must commit to implement nationally agreed and mandatory service standards in mental health services as they have for other health services. The National Mental Health Commission will work with the Australian Commission on Safety and Quality in Health Care to identify what it takes to get proper uptake of national mental health service standards and make them mandatory.

Recommendation 7:

Invest in healthy families and communities to increase resilience and reduce the longer-term need for crisis services.

Action: Increase enhanced and personalised support for parenting through culturally relevant forms of home based visiting (antenatal and in the first few years of life). These must be provided at a local or regional level. There must also be active follow-up where a family is under stress or experiencing tough financial or social difficulties.

Recommendation 8:

Increase the levels of participation of people with mental health difficulties in employment in Australia to match best international levels.

Action: The National Mental Health Commission will pull together a taskforce including industry, government and community leaders, to actively promote effective government and workplace programs that increase the participation of people with mental health difficulties in employment. The Commission will partner with key industry and community groups to Call for Evidence and work together to advance the adoption of good practice in Australia.

Action: Employment support programs, initiatives and benefits must be more flexible. They must recognise that mental illness comes and goes — and what that means for people and their families. Programs must provide long-term support for the employee, families and support people and the employer, with appropriate incentives and milestones.

2013

Recommendations

Recommendation 9:

No-one should be discharged from hospitals, custodial care, mental health or drug and alcohol related treatment services into homelessness. Access to stable and safe places to live must increase.

Action: All governments implement and report regularly on the existing COAG commitment of ‘no exits into homelessness’ from statutory, custodial care and hospital, mental health and drug and alcohol services for those at risk of homelessness.

Action: Discharge planning must consider whether someone has a safe and stable place to live. Data must also be collected on housing status at point of discharge and reported on three months later, linked to the discharge plan.

Action: Governments must commit to removing any structural discrimination barriers to accessing housing. Just as important is providing support to help vulnerable residents to settle in, adjust and remain in their homes.

Recommendation 10:

Prevent and reduce suicides, and support those who attempt suicide through timely local responses and reporting.

Action: Develop local, integrated and more timely suicide and at-risk reporting and responses. Developing and rolling out well co-ordinated community-based, culturally appropriate, early response systems and suicide prevention programs which promote community safety, reach the most vulnerable, and using up-to-date information from the ‘first responders’ such as police officers, occupational health workers, ambulance officers and mental health workers.

And in 2013 we add a further action...

Action: Programs with a proven track record (which are evidence-based) must be supported and implemented as a priority in regions and communities with the highest suicide or attempted suicide rates – action needs commitment and a humane approach.

Co-existing mental illness and substance misuse

People who experience co-existing mental health difficulties and substance misuse can live contributing lives if they are able to access appropriate services and support for both issues. These people are too often discriminated against and treated as though they are less worthy of help. Their needs must be responded to in a comprehensive, integrated way wherever they present. Workers on the ground are often not supported to work in this way. That may be because of siloed structures, inadequate funding or constraints on professional development and supervision.

Recommendation 11:

People with co-existing mental health difficulties and substance use problems must be offered appropriate and closely co-ordinated assessment, response and follow-up for their problems.

Action: We must have a mechanism to test compliance with ‘No Wrong Door’ practices and ensure they do not exclude or discriminate against people with co-existing mental health and substance misuse problems. The benchmark for this must come from the experience of people affected by these difficulties, their families and supporters. Then we can start to measure uptake of policies and impacts on peoples’ experiences.

Action: The Commission calls for innovative responses in this area that do not discriminate against people with co-existing difficulties – particularly around integrated services, funding and policy. These must embed appropriate assessment, treatment and professional supervision and be systematically evaluated. This will expand our understanding about what works, and help develop more effective models of practice appropriate to different groups.

Action: Funding must facilitate these actions, not create barriers to them.

Early intervention

We support early intervention and acknowledge the significant recent investment in these initiatives for young people. It is important that these services are given enough time to bed in. We need to build in robust evaluation with outcome measures and accountability of these services to young people and their families and supporters. The concept of early intervention for people at any age or stage of life should remain a high priority.

Recommendation 12:
National, systematic and adequately funded early intervention approaches must remain. This must be accompanied by robust evaluation to support investment decisions, with a focus on implementation, outcomes and accountability.

Action: People using services, their families and supporters must be engaged with co-design, evaluation and monitoring of early intervention initiatives.

Action: Continuous practice improvement must be driven by the findings of ongoing independent rigorous evaluation and appropriate accountability.

Peer workforce

Delivering recovery-focused services must involve growing and properly supporting our peer workforce. Without exception, the peer workforce includes both people with lived experience and personal carers. To do this, we need clear employment provisions and working conditions, training opportunities, professional capabilities and workforce development strategies, including supervision and mentoring requirements. All must be standardised nationally.

Recommendation 13:
A National Mental Health Peer Workforce Development Framework must be created and implemented in all treatment and support settings. Progress must be measured against a national target for the employment and development of the peer workforce.

Action: All governments and agencies must work together and with suitably experienced people with lived experience and their families to agree and implement a National Mental Health Peer Workforce Development Framework.

Action: This framework must identify a target and implementation strategy for the employment of peer workers in all support and treatment settings.

Action: The Certificate IV Peer Work training materials developed by Community Mental Health Australia must be rolled out nationally when available.

Action: Effective approaches to the meaningful inclusion of families and informal support people exist, and these must be harnessed and incorporated into a national practical guide.

Including families and support people

People with lived experience of mental health issues, either personally or as a support person, tell us that the most important enabler to a contributing life is strong and supportive relationships and connections. However, what we have heard is that families and support people, when coming into contact with services, are too often excluded and perceived as irrelevant.

Recommendation 14:
A practical guide for the inclusion of families and support people in services must be developed and implemented, and this must include consideration of the services and supports that they need to be sustained in their role.

Action: The Commission will use the Contributing Life survey to assess compliance with these principles. This will complement the work being developed on the Consumer and Carer Experience of Care tool.

Community understanding

While concerted efforts mean that Australians are becoming more aware of and talking more about mental health and suicide, the Commission continues to hear about individual and systemic discrimination and misunderstanding. In particular, people living with certain illnesses, such as psychoses, continue to face entrenched discrimination, which only adds to their marginalisation.

Recommendation 15:
The Commission calls for the implementation and ongoing evaluation of a sustained, multi-faceted national strategy for reducing discrimination.

This should encourage positive and affirmative action by every person, family, service, school, workplace and community to help others to live a contributing life. It must be centred on community-level initiatives, and be targeted at areas and groups most resistant to change and where there is the most potential to bring about improvement, consistent with the evidence.

Action: We will continue to work with others to consider ways to end the vilification of people with mental illness.

Action: We need more targeted anti-discrimination initiatives, beginning with those who come into frequent contact with people with mental health problems and their families and support people, as well as those among whom discrimination is the greatest.

Transitions through education

All transitions and changes can be challenging, but particularly so for people living with mental health problems. Our years in kindergarten, school, vocational college, TAFE, apprenticeships and university see some of life's biggest transition points. Our education and training systems know this and support us through these. However, people with mental health difficulties may need additional support and more innovative pathways so they keep connected.

Transitions and changes occurring in education and training must not leave people with mental illness behind, but rather create opportunities to keep them engaged in education, employment or training to live productive and contributing lives. This is especially important for young people living with mental illness, from disadvantaged backgrounds, those who live in rural and remote areas, and Aboriginal and Torres Strait Islander peoples.

Recommendation 16:
All Australians need access to alternative (and innovative) pathways through school, tertiary and vocational education and training.

There are already many good examples of these which must be recognised, valued and scaled up. This is crucial to engaging people who are disconnected and for whom 'mainstream' institutional structures form barriers to a contributing life.

Action: Australian governments must collect data, and report nationally on the educational participation of people experiencing mental health difficulties. A target must be set to reduce the numbers of those with mental health problems falling into the "not in education, employment or training" (NEET) group, thus tracking our progress against that of other countries.

The justice system and mental health

The Commission knows of examples of contact with the criminal justice system and diversion schemes being an opportunity for people with a mental health problem to start on the path to a contributing life. All too often, however, this contact is not only damaging to their mental health but also to whole-of-life outcomes.

People who experience mental health problems who are in contact with any part of the criminal justice system and their families and support people need approaches which support their mental health needs and improve personal outcomes, and which also reduce recidivism rates.

The Commission finds that there are strong human rights, health and economic arguments to address these failings. It is in the community's interest for the criminal justice system to respond appropriately to mental health issues while a person is in corrections services, to prepare them to rejoin the community and to follow up with them on their release. The criminal justice system should not create or contribute to further mental health problems, and must provide opportunities for assessing and addressing mental health issues.

Recommendation 17:

Where people with mental health difficulties, their families and supporters come into contact with the justice system and forensic services, practices which promote a rights and recovery focus and which will reduce recidivism must be supported and expanded.

These include:

- diversion services to create pathways for people with mental health problems away from prison and into support and treatment;
- justice reinvestment for Aboriginal and Torres Strait Islander peoples and people with mental health issues who are in contact with the justice system; and
- arrangements that give better rights protection, supported transitions and follow-up for people with mental health issues in custody, prison and forensic facilities when they are released or discharged. These must include step-down forensic services and supported community accommodation.

Action: State and territory governments must scale up diversion schemes, justice reinvestment, and transition support.

Action: State and territory governments must provide better mental health programs to those who come into contact with the justice system, so that people have their mental health improved rather than diminished.

Suicide prevention

It is unacceptable that at least 2,200 lives are lost to suicide in Australia each year. Suicide affects young people disproportionately and as a result is a leading cause of healthy life years lost in our country. It compounds and reflects existing patterns of disadvantage in Australian society.

In addition, there were an estimated 65,300 suicide attempts in 2007 reported by the Australian Bureau of Statistics. The biggest risk factor for suicide is a previous suicide attempt. We have limited understanding of what people experience leading up to and after a suicide attempt.

An internationally tried and tested way to focus minds and encourage co-operation and action is to introduce a national target for a reduction in the suicide rate. The COAG Expert Reference Group on mental health reform has proposed a reduction in the national suicide rate by 10 per cent in four years and 50 per cent in ten years.

The Commission supports this ambitious goal.

This Report Card shows how little we know about what works to bring population suicide rates down. Practical and detailed implementation plans are required to realise this ambition.

To give further impetus to the implementation of last year's Recommendation 10, we recommend that:

Action: Programs with a proven track record (which are evidence-based) must be supported and implemented as a priority in regions and communities with the highest suicide or attempted suicide rates – action needs commitment and a humane approach.

Recommendation 18:

Governments must sign up to national targets to reduce suicide and suicide attempts and make a plan to reach them. These targets must be based on detailed modelling.

Action: This modelling must:

- incorporate the best current evidence from Australia and proposals for small-scale piloting of approaches with promising evidence. It should identify where targeted research is most needed;
- identify proposals for how practical collaboration can be fostered – as the basis for a systemic approach to suicide prevention. This applies not just across government departments and between federal and state governments. It also means collaboration at a local level between providers of health, welfare, employment, education, housing, legal and justice sectors, and also between providers and users of services and supports; and
- determine priorities for investment. We know little about the cost-effectiveness of suicide prevention approaches, and we need to start by undertaking robust evaluation of existing initiatives.

Action: Existing community-based suicide bereavement support activities for families and support people must be scaled up and new ones encouraged – particularly in Aboriginal and Torres Strait Islander communities.

Action: Australia needs a national picture of the contributing factors to suicide attempts, starting with those most at risk, so we can work out sensitive responses to those groups, marshal resources and, over time, measure our success.

It is vital to hear from those who have survived a suicide attempt and from their families and supporters about what helped and what made things worse at the time. To contribute to this effort, the Commission has initiated a small study by the Centre for Research Excellence in Suicide Prevention into peoples' experiences leading up to and following a suicide attempt.

The 2013 Report Card chapters

Thriving, not just surviving

One person, diverse needs: living with a mental illness as well as the challenges from difficulties with alcohol and drug use

[Link to chapter](#)

Governments, community agencies, and public and private services must do away with historical silos and isolated approaches. We can have a cycle that leads opportunity to another opportunity, rather than disadvantage leading to further disadvantage. A stark example of a stubbornly fragmented approach is how we support people with **co-existing mental health and substance use problems**. All too often, the presence of one of those challenges means exclusion from services designed to support the other.

Only seven per cent of people with co-existing mental illness and substance misuse have received support for both problems,⁴⁰ yet studies have shown that up to 70 per cent of people presenting to mental health or substance use services can experience both issues.⁴¹

Maintaining connections with family, friends, community and culture

Strengthening community understanding

[Link to chapter](#)

If we see equal opportunity for a contributing life as a human right, we can start to recognise and remove the barriers to accessing the building blocks for such a life. This begins with recognising and dismantling entrenched institutional and individual discrimination through **strengthening community understanding**.

About a quarter of the first participants in a Commission snapshot survey this year said that social discrimination got in the way of them feeling connected to family, friends, culture or community.¹¹

Ensuring effective care, support and treatment

Approaches that support recovery, including early intervention

[Link to chapter](#)

If the right support is available at the right time, and everyone knows about it and has an equal chance to access it, the vicious cycle of illness and disadvantage can be interrupted or averted. We focus on how this can happen in the chapter about **early intervention**.

Fourteen per cent of Australia's children and young people have mental health problems.³⁵ Young people with mental illness are less likely than their classmates to complete secondary or tertiary education.⁴² Fifty-two per cent of 20-24 year olds with a disability from a psychological illness had not completed Year 12 or higher qualifications, compared to 25 per cent of people with other types of disability,⁴³ and double the rate of the rest of their schoolmates (16.5 per cent of their age group).⁴⁴

Something meaningful to do

Transitioning from education to independence

[Link to chapter](#)

We all experience times of change and transition. If a young person begins to experience difficulties with their mental health, it's vital that they are supported to get through periods of difficulty – especially during transition points. We look at what is needed to build strong foundations for a contributing life in **education to independence**.

Young people aged 15-24 years who have a mental illness and completed up to Year 11 at school, have lower rates of engagement in work or study than their classmates who did not have a mental illness. For this group of young people with a mental illness, 55 per cent are either in full- or part-time employment or full- or part-time studying, in contrast to 81 per cent of their classmates who do not experience a mental illness.⁴⁵

Feeling safe, stable and secure

The justice system and mental health

[Link to chapter](#)

We know that people with mental illness are over-represented in our prisons. We know that people can turn their lives around with the right supports. It can be done. The **justice system and mental health** chapter talks about how we can do this.

Nationally, one third of prisoners with a mental health condition have been in prison five or more times, compared to 26 per cent of prisoners with no condition.⁴⁶

Preventing suicide

What works in suicide prevention?

[Link to chapter](#)

Sometimes people can get locked into a situation which feels impossible and hopeless. This can culminate in one of 65,300 suicide attempts⁴⁷ and 2,200 reported deaths from suicide every year in Australia.²¹ In our suicide prevention chapter, we look at what we know about **what works to prevent suicide** and how we can stop this tragedy happening for any more people and families.

Every year, suicide takes more than twice as many lives in Australia as traffic accidents.²¹



Thriving, not just surviving:

One person, diverse needs:
Living with a mental illness as well
as the challenges from difficulties
with alcohol and drug use

Lani, Queensland

I was diagnosed with bipolar 2 and ADHD in 2006. I was 24 then. After going through an extreme manic episode, I knew I needed help. And fast.

When I look back on the years preceding my diagnosis, there were big warning signs I wasn't well. From the age of 16, my head suddenly began to operate independently of what I wanted it to do. I now understand that was bipolar. Back then I thought it was normal.

So I began to self-medicate. A treatment plan I devised myself; so dangerous to someone with mental health issues.

Over the next eight years, I struggled with alcohol and drug use. I couldn't just drink a few drinks. I had to wipe myself out. For that was my intention always. I didn't want to feel the hurt from depression and I wanted to numb the confusion and anxiety of hypomania.

The comedowns were horrifying but that brief moment of escape made it seem worthwhile.

Until I kept going down, down, down.

I'm now on an extensive treatment plan that includes medication, therapy, being mindful and working with my amazing husband, family and friends. I have two degrees, about to start my Masters, a great job and am leading a life I'm proud of.

I've found that doing the things I love helps greatly. For me that includes writing, reading, study, sport and music. I still have my down days, my up days and my all over the shop days. But doing the things I love regularly keeps me excited, engaged, and looking to the future.

I have to confront my mental illness by managing it every day. It doesn't own me. I can own it. I no longer just want to survive. I want to thrive.

*I choose happiness. I choose health.
I choose life.*



Watch Lani's video at www.mentalhealthcommission.gov.au

Introduction

The Commission recognises that the ability to live a contributing life is hindered for many people who live with the combination of drug and alcohol problems and mental illness.

The effects of experiencing both problems in tandem can be devastating for people, their families and supporters. People living with this mix of difficulties are discriminated against and are often judged and marginalised from services and the community.

They will have major challenges in their life and the social and health impacts of both problems are huge. People will most often start to use substances in adolescence,⁴⁸ a time which is usually for forming identity, establishing relationships and completing education.

People with mental illness and substance use disorder will have their life expectancy reduced by up to 30 years³² and are twice as likely to smoke as the general population⁴⁹. Although they have a high need for both physical and

mental health support they will be reluctant to walk into a health service and ask for help.

People with this combination of problems will also be more likely to experience suicidal thoughts.⁵⁰

This is a tragedy.

The Commission wants to emphasise that substance use disorder is an illness – like cancer or heart disease. People with this illness should have the same human rights and should have the same access to appropriate health care and treatment as people who have physical health problems.

We have heard that this is not the case.

People with this mix of problems and their families and supporters will knock on many doors for help. They might ask for a safe place to

sleep or help with money, for help with addiction or legal advice. It is essential that every door which is knocked on is a door which can lead to the right pathway to support, care and treatment.

We have heard that there is often nothing behind the door from people and their families.

In this chapter we will shine a light on the challenges faced by people who experience co-existing mental health and drug and alcohol use. We will look beyond policy and research, where much progress has already been made, towards the call for development of new models of care where much potential can be realised to change lives.



What we know

We know that in a year, almost 340,000 Australians will have both mental illness and a substance use disorder.⁴⁷

For many people, challenges at school, early exposure to drug use, difficult family relationships, a lack of community cohesion and poverty can lead to problems with drugs and alcohol.^{51,52}

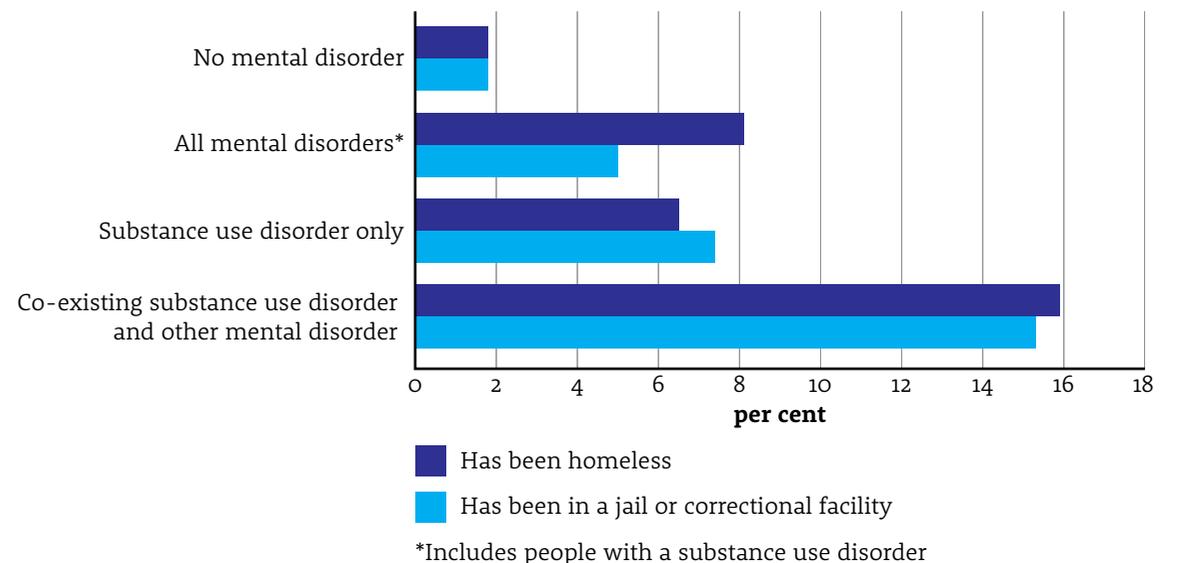
We know that a large number of people who have a mental illness will use substances at some stage, and vice versa. This may not be at a level that is problematic or needs a

specialist alcohol and drug service.⁵³ Many will have their needs met from local supports whether it be a mental health or drug and alcohol service, or by their GP.

Here we focus on people living with a mental illness who are most significantly affected by substance use. We use the term 'substance use disorder' to describe their illness.

We know that misuse of different drugs affects people in different ways and has variable health and social impacts. For example, people who have mental health issues and a substance use disorder are twice as likely to be homeless as those who had one of these problems, and twice as likely to have been in prison or a correctional facility (refer Figure 1).⁴⁷

Figure 1: Percentage of people who have ever been homeless or in a correctional facility, by mental health status



Source: 2007 National Survey of Mental Health and Wellbeing



Our emergency services are heavily impacted by alcohol and drug misuse. Recent data from the Victorian Ambulance Service shows that of 5,993 callouts to people with depression between June 2012 and May 2013, **alcohol was involved in 29 per cent**, with **drug use being present in 38 per cent**.⁵⁴



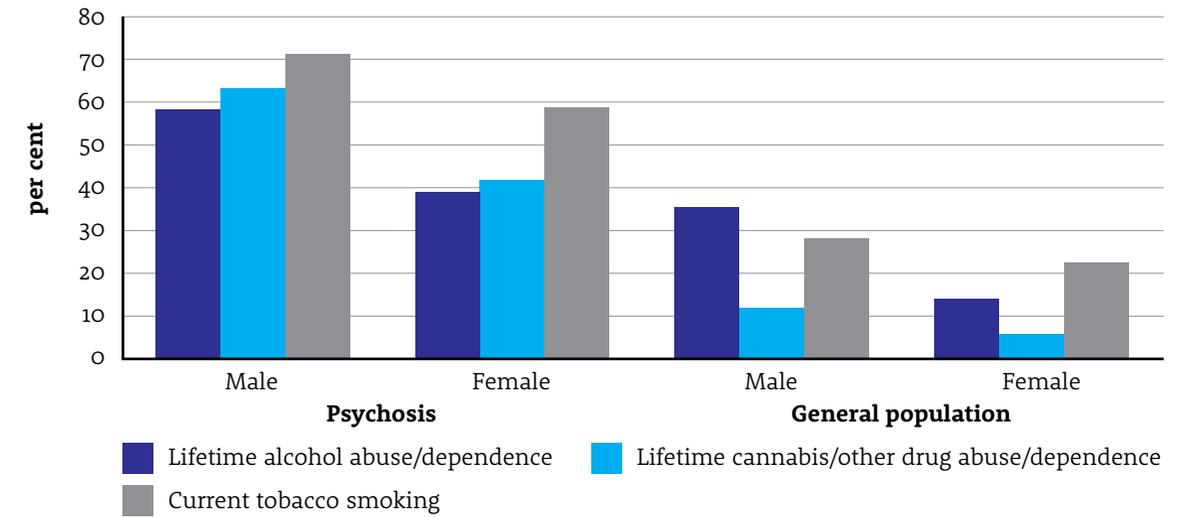
The range of effects of different drugs and the impacts on people and communities needs to be recognised and understood:

- People with a mental illness are twice as likely to smoke.⁴⁹ **Nicotine** addiction is often overlooked when talking about co-existing mental illness and substance use disorder, but remains a major cause of death and illness in Australia, with people living with a mental illness smoking at higher rates compared to the general community.⁴⁹

- For people with psychosis, their lives are more likely to be affected by problematic substance use across their lifetime in comparison to people without psychosis.⁵⁵ Figure 2 shows the disproportionate use of alcohol, drugs and nicotine by people living with psychosis compared to the general population.
- Long-term **cannabis** use is common in people experiencing mental illness, in particular for those with psychosis.⁵⁵ Prolonged use has been associated with psychotic symptoms.⁵⁶

- There is a strong association between **methamphetamine** (“Ice” or “crystal meth”) use and psychosis, with some studies showing that the prevalence of psychosis in methamphetamine users is 11 times higher than in the general population.⁵⁷
- There is an association between completed suicide and **alcohol** consumption⁵⁸.
- We know that in Aboriginal and Torres Strait Islander communities, a large proportion of people refrain from drinking but those who do drink often do so at high risk levels.⁵⁹ Indigenous men die from alcohol-related causes at a rate nine times higher than non-Indigenous men.⁶⁰

Figure 2: Drug use by people living with a psychotic illness compared with the general population



Sources: 2007 National Survey of Mental Health and Wellbeing and 2010 National Psychosis Survey

- We know that excessive alcohol consumption is associated with **physical health problems** such as cardiovascular disease, liver disease and diabetes.
- We know advances have been made in research about treatment approaches for co-existing conditions and we recognise that many services promote a principle of shared care or ‘no wrong door approach’.

But we hear this has made little difference to the lives of people and their families. Of great concern, is that despite the high health needs of these people, we know that use of health care services is no greater by people with co-existing disorders than those who live with a mental illness alone.

Despite isolated examples of good practice, estimates show that only seven per cent of people with a co-existing mental illness and substance use disorder will receive treatment for both problems.⁴⁰

We know that delay and reluctance to seek treatment places great stress on families and support people – as does the reliance on them to navigate a fragmented system. As a result, families and support people often experience financial hardship, compromised emotional and physical health, risks to personal safety and family conflict.⁶¹

What the evidence shows is good practice

The *National Co-morbidity Project* has made great strides in identifying good practice.

Clinical treatment guidelines have also been developed, including those on the management of *co-existing alcohol and other drug and mental health conditions*.⁶²

Despite the advances in research, there is comparatively little evidence of true integration of care occurring at the coal face.^{53, 63}

We know that the problems that people face with co-existing mental illness and substance use disorder are far reaching. There is often no quick fix. For this reason, the most promising practices are those which address a person's whole-of-life needs concurrently, rather than addressing one at a time.

This means working with the person; meeting them where they are, for example, providing assertive outreach to people who are homeless, or addressing their needs within the service where they first seek help. When a person arrives at a service, a thorough assessment of the substance use should precede any treatment.

This should look at the impact of the substance use on the person's relationships, work, leisure, accommodation, physical health and harm. Consideration should be given to the person's motivation and preference for what they think should be the next step in their recovery journey.⁶⁴

“I would make it so that people don't have to all fit into a box (in terms of their mental illness). As I think there are a lot of areas in between that aren't catered for.”¹¹

Good practice means an end to leaving it to people and their supporters to take responsibility for co-ordinating different elements of care.

It means meeting peoples' needs in the first instance and stopping the revolving door.

A number of therapeutic communities, such as We Help Ourselves⁶⁵, Odyssey House⁶⁶ and Ted Noffs' *PALM* program,⁶⁷ although set up and funded primarily to assist people with drug and alcohol addiction, do not discriminate against those with co-existing difficulties and will arrange concurrent treatment as part of the person's care.

Lyndon Community in Orange, New South Wales shows promising practice and the integration of physical and mental health wellbeing programs, drug and alcohol treatment and principles of mental health recovery in the one place.⁶⁸ We know that there are other organisations providing flexible and integrated care to improve access to treatment for people with co-existing conditions, and it is more of these approaches that are needed.



Good practice is also about timely interventions.

Early intervention can change the life trajectories of many people with co-existing mental illness and substance use disorder, particularly for young people and people from disadvantaged backgrounds. Evidence suggests that three-quarters of adult mental health and substance use disorders begin by the time people are in their mid-twenties.³⁶ This suggests that practices that involve a broad range of supports for young people – from schools, their GP, as well as specialist services – all have a role.



Good practice gets a tick from the Commission

Spotlight issue

‘No wrong door – or is there nothing behind it?’



For people living with co-existing mental illness and substance use disorder, navigating daily life is challenging enough without having to put up with encountering support services which don't communicate with each other.

This means people have to repeat their story again and again and only one aspect of their illnesses are dealt with. They face different eligibility criteria, referral systems and paperwork.

A ‘no wrong door’ approach underpins Australian health policy for services supporting those with co-existing problems. In practice, this means that every door in the public support service system should be the right door with a range of services being accessible to everyone from multiple points of entry. This commits all services to respond to the individual's needs through either providing direct services

for both their mental health and drug and alcohol problems or linkage and case co-ordination, rather than sending a person from one agency to another.

However, we continue to hear about separate systems, with workers not having sufficient time or resources to do further work beyond only the assessment of co-existing mental illness and substance use disorder.⁴⁰ Nonetheless, it is widely recognised that working with people with co-existing disorders is core business of both drug and alcohol *and* mental health services, and this should be the expectation rather than the exception.⁶⁹

We are not talking about small numbers. One in ten people with a mental health disorder have a co-existing substance use disorder.⁴⁷ It is incomprehensible that services and supports may operate without this dual perspective.

There are a number of options that embody the ‘no wrong door’ ethos and have the potential to change outcomes. Integrated care does not necessarily mean integrated funding or a specialist service.

“Reduce the form-filling and referral run-around. Reduce the emails and phone calls. Reduce the red tape. Reduce the intrusive questions from the next professional and the next professional, when you have done it all before over and over again.”¹¹

Some potential models are:

- Nominating a liaison person to work between drug and alcohol services and mental health services to develop clear pathways in local areas. This can nurture improved communications, referral protocols and joint approaches.
- Augmenting mental health teams with a specialist drug and alcohol

worker who is still able to access professional support in their original discipline and is able to retain their skills and expertise, and vice versa. It is important that this worker does not become a case manager, but is used for up-skilling colleagues and for specialist interventions.

- Creating a specialist integrated team with

professionals and leadership across both disciplines.⁵³

A recent study looked at 17 Australian ‘co-morbidity services’ considered to represent good practice. This found that whichever model is used, it is vital that there is flexibility in the way support is provided to each person because of the complexity of this set of needs.⁶³ Supporting a brother

Supporting a brother

What it means for Kristine, New South Wales

My brother was a son, a husband, a father, a grandfather, and a pastor. This story is about how his life ended tragically after many, many years of service providers passing the buck and not assisting him for both his mental illness and his alcohol use.

There were numerous occasions when he was admitted to hospital with physical injuries. Each time he was admitted we tried to get help for his mental health as well, but he was discharged on his word. He presented with the smell of alcohol on his clothes and was labelled a 'drunk'.

One day he attended court to answer a drink driving charge. He was drunk. The judge said he did not know what to do with him and decided to send him to prison. After prison he went to rehab to treat his alcohol abuse.

He passed out at the Rehab Centre and by the time the ambulance arrived he had recovered consciousness. The rehab would not allow him back if he was put on medication for his mental health.

When he arrived at the hospital the staff assessed him and asked him if he was a threat to himself. He said 'no' so they waited for a doctor.

He wanted to call his wife, using their phone because he had not brought any money with him from rehab, but they refused.

My brother had issues with alcohol his whole life and because of this he was denied services which could have helped him with his mental illness. He took his own life while at the hospital because he couldn't get the help he needed.

I believe service providers need to treat mental illness, physical health and drug and alcohol use together. Not separately.



Watch Kristine's video at www.mentalhealthcommission.gov.au



What we don't know

Where we need more evidence and to shine a light

It is clear that there is a close and often complex relationship between mental illness and substance misuse. The nature of the relationship and the pathways to mental illness from drug use is not clearly understood; however, Australia has made advances in this area of research. Some common theories are as follows:

The first theory is that mental health problems contribute to problems with alcohol and other drugs. For example, alcohol can be used to relieve feelings of anxiety prior to a social occasion. Over time, the alcohol becomes relied upon and problems can develop.

The relationship may also work in the other direction. An accumulation of loss, exposure to trauma and difficult circumstances due to prolonged alcohol and drug use may contribute to the development of depression and Post Traumatic Stress Disorder (PTSD) in particular. Research has shown that acute alcohol

use is associated with suicide.⁵⁰ Alcohol dependence has also been shown to be associated with suicidal behaviour.⁵⁸

The third explanation is that both mental illness and substance use problems arise from the same environmental factors and from genetic sources.

Studies examining the relative influence of these three theories tend to support the third explanation most strongly. It may well be that the role of different pathways is variable between people and between specific combinations of disorders.

More studies are needed to develop treatments for specific combinations of different disorders. The approach for co-existing schizophrenia and cannabis use will differ from that for co-existing PTSD and alcohol use disorder. In most treatment studies, people with multiple disorders tend to be excluded as it is recognised that poor outcomes are more likely where disorders co-exist. Integrated treatments for PTSD and substance use disorders have been developed and trialled with a number of concurrent treatment approaches showing promise.⁴¹

Progress in research into co-existing mental illness and substance use disorder are yet to flow in to practice. Many misconceptions still persist, such as that the treatment of the primary disorder may resolve the secondary disorder; there can be a reluctance of professionals to treat both issues at the same time.⁶⁴

We need more evidence as to what types of services and interventions could best meet the needs of this group of Australians and at what point a person with both problems would require help from a specialist service.

Many people who require help with substance misuse can experience symptoms of depression or anxiety. They may not need specialist support for both issues. Integrating services therefore requires further research and a clear definition of who would be eligible for and in need of such services.

More work is needed on how different professions work together in an integrated team, while respecting the others' specialist experience, and ensuring adequate access to professional development and supervision.

We know that a few integrated models internationally exist to provide services to people with co-existing mental illness and substance use disorder, yet their long-term effectiveness and appropriateness for use in Australia has not been tested.

We do not know if current programs are meeting the needs of Aboriginal and Torres Strait Islander peoples, CALD populations and LGBTI communities or whether integration on its own would respond to the needs of these diverse populations. Further exploration of mental health literacy in diverse populations is needed to ensure culturally appropriate service planning.

Helping people with drug and alcohol problems to thrive

What it means for Rod, New South Wales

I work at The Lyndon Community where we provide alcohol and other drug treatment in both residential and non-residential programs. We've been doing this for over 30 years and have a range of services, including withdrawal, rehabilitation and outreach.

We see a lot of people with co-existing mental health and drug and alcohol problems. Sometimes it's difficult to work out the root cause of a person's suffering.

People are complicated. There is no rule that says they can have just one problem. Labels do not help people unless they are correct and the person themselves sees the benefit in being diagnosed. It's also vital that they have an effective management plan that will help them achieve positive outcomes for the future.

As an Addiction Medical Specialist at The Lyndon Community for the past 12 years, I've come to believe that professionals really need to work in a holistic manner to ensure service delivery is not fragmented for those in need.

I've seen many positive changes in the mental health sector over the years. Evidence-based practice has improved significantly along with better staff education, enhanced liaison with professionals including social workers and psychologists, and improved staff education at all levels starting from those on the ground.

Better integration of mental health concerns into the drug and alcohol services has made a huge difference too. There's also more awareness of latest research into how drugs and alcohol can potentially affect clients dealing with mental health issues.

Working at The Lyndon Community gives me hope for the future. I believe there is a real positive in up-skilling our staff in current research and education, which leads to improved help for our clients. I also believe the flexibility we have as an NGO is excellent. It places us in a unique position to be able to work with individuals on a needs basis. This has seen us engage with smaller populations of people who don't access mainstream services.

 Watch Rod's video at www.mentalhealthcommission.gov.au



Where the Commission is looking for continuous improvement

We have basic information about the prevalence of co-existing mental illness and substance use disorder in Australia.

Part of the problem is that in research, people are often asked if they experience any mental health, alcohol and/or drug use problems in a single question. This makes it impossible to identify people with co-existing mental illness and substance misuse. The Commission calls for development of such data as a basic requirement for service development and improved integration.

We know that primary care is often the first point of contact for many people with co-existing mental health difficulties and substance misuse problems, with estimates showing that around two people per day in an average General Practice are presenting with co-existing mental illness and drug use.⁴⁰

This is a significant opportunity, and improvements could be made to better support GPs to identify issues early and deliver or refer people to supports.

Good case management, appropriate clinical supervision and access to expertise in dealing with both mental health difficulties and substance misuse problems can help support services to identify and meet the needs of those affected. The Commission looks for advancement in this area as well as the testing of new support models and innovative practise to provide integrated care.

We need greater recognition of co-existing mental illness and substance use problems experienced by people in contact with the criminal justice system. More insight is being gained into the mental health and wellbeing of prisoners with the National Prisoner Health Surveys.⁷⁰

Unfortunately, the data collection tool does not as yet allow for identification of co-existing conditions.

An integrated treatment approach while in prison and subsequent co-ordinated health and social services on release from prison could not only reduce the impact of their illnesses on the person but also has the potential to reduce re-offending. Diversion of people to programs such as the New South Wales Drug Court, have been effective in reducing recidivism.⁷¹ The Commission welcomes more innovation and development in this area.

People with mental illness and co-existing substance use problems are heavy users of a number of public services such as housing, Centrelink and primary health care. Using multiple support services requires repeated form-filling to provide the same information to every service. We would welcome solutions to these burdens for people who are often living in chaos.

Although research has advanced and a number of services in Australia show promising practice, it is relatively hard to find truly integrated care models that consider the whole person and their full range of needs. Further exploration and implementation of flexible models to suit the demands of specific communities is vital.

The Commission looks for urgent and rapid improvement in this area, given the unacceptably poor health and social outcomes for people who experience mental illness and substance use disorder, and their families.



Maintaining connections with family, friends, community and culture:

Strengthening community understanding

Jack, Victoria

The seeds of mental illness were planted when I first started school. I couldn't talk properly and I was overweight. I felt pretty inadequate, was very shy, and had poor self-esteem. So kids laughed at me and teased me.

In my 20s I was involved in the local football club. I was out late drinking then early the next morning I would get up to do the milking on the farm. Something was bound to give and it did. I was admitted to a psychiatric institution.

Dad was a great support when I was unwell. He called my friends and told them what had happened. These conversations removed a lot of the stigma of mental illness. They were on board with being my support network straight away.

When I returned home from the psychiatric facility I had lots of side-effects from the medication which prevented me running the farm. Dad came out of retirement to help out. I would milk with Dad's help in the early mornings and evenings and then sleep during the day. Even though I resented the early morning milking at the time, it was a good thing to have a routine. Today, I have been lucky enough to keep the family farm.

My wife thought it was a good idea to tell my story. Now I talk about mental illness and stigma with Year 9 students. One of the key messages I tell the kids is 'say positive things, don't tell them what they have done wrong'. I want to let people know that mental illness is not the end of the world.

Life is like a game of football. Sometimes life is going pretty good and you are winning by 10 points. But sometimes you lose by 5 or 6 points and you feel pretty helpless and you wonder what went wrong. You can analyse the game, work out what happened and not make the same mistakes.

This is like my life. Although I have had some bad things happen, in the long run my life has been a blessing.

And so it is with your life.



Watch Jack's video at www.mentalhealthcommission.gov.au

Introduction

The way that we as a community often shun people who live with a mental health difficulty⁷² erodes their quality of life. Everyone has the right to be treated without discrimination, but for people experiencing mental illness, being ignored, talked down to, or treated ‘differently’ is a lived reality in everyday interactions.⁷³

Ending discrimination about mental illness starts with individuals, families, schools, workplaces and communities.

Strengthening community understanding helps build peoples’ capacity to identify and better understand the early signs of mental distress. But understanding is not enough by itself – it must be used to help improve lives on an everyday basis. It must be used to help us change our behaviour from a tendency to withdraw and ignore towards a tendency to reach out and support.

We can provide inclusive environments where people with a mental health difficulty and their families will feel more confident about not encountering discrimination – and to call it when they do – and so access the services and supports they need.

Communities that are diverse are stronger when people have an understanding of each other.⁷⁴ Strong communities contribute to our wellbeing. These benefits are undermined when we feel excluded from participating and when there is little acceptance of diversity. All too often people with mental health difficulties experience this, and frequently raise stigmatising attitudes as their greatest concern.¹¹ This experience of stigma and discrimination also affects their families and support people.

This chapter will focus upon how our understanding of mental health issues affects how we treat or discriminate against people living with a mental health difficulty and their family or support people. It will look at how well our communities understand

mental health, and what the consequences of poor understanding are for us as a community and for the lived experiences of people with a mental health difficulty to lead a contributing life.

Under the *Australian Disability Discrimination Act 1992*, discrimination is defined as the treatment of (or proposal to treat) another person less favourably on the basis of their disability when compared to other people. This can be intended or unintended, and this law applies to how ‘people with a psychiatric disability’ are treated as well as their families and support people.⁷⁵

We will look closely at discrimination at the broader community and institutional scale, as well as at the micro-scale of individual interactions.



What we know

In just about every sphere of life – making friends, living next door to or working closely with someone, falling in love – we know entrenched discriminatory attitudes exist. Too many of us still hold discriminatory and prejudiced views about mental illness and towards people who live with schizophrenia.^{55, 76}

The 2011 *National Survey of Mental Health Literacy and Stigma*⁷⁶ found that:

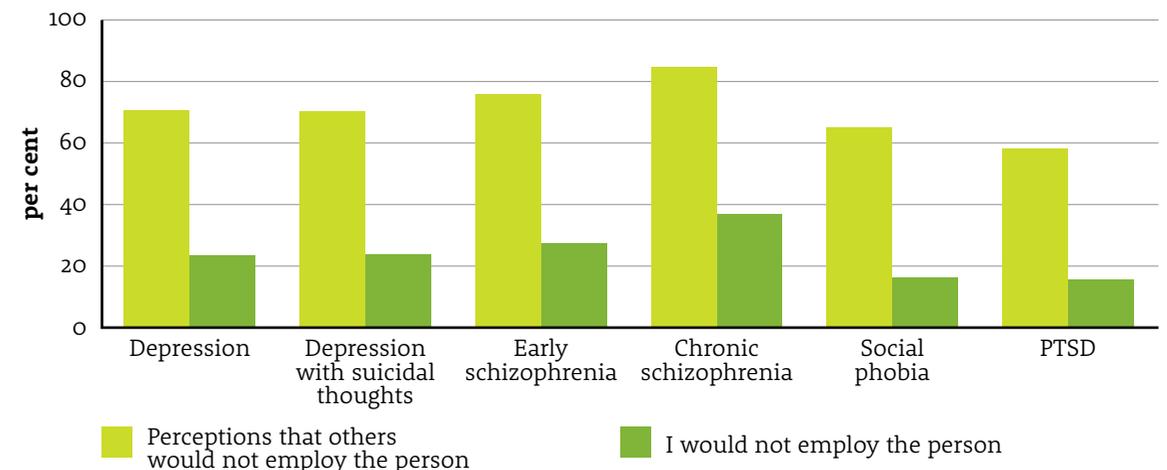
- just under half (45.1 per cent) of people surveyed indicated they would not want a person with schizophrenia marrying into their family and around a quarter (28.2 per cent) would not want someone with depression marrying into their family;

- between 32.6 per cent and 48.6 per cent of people would avoid someone with a mental health difficulty – from avoiding people with Post Traumatic Stress Disorder (PTSD) to those with chronic schizophrenia;
- 37 per cent of people would not employ a person with chronic schizophrenia and 23.4 per cent would not

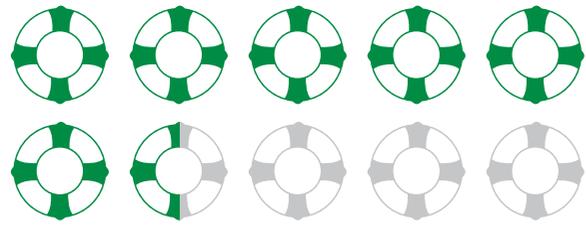
employ someone with depression.

It is unacceptable that people who live with the most disabling mental illness also face the most discrimination and misunderstanding, as Figure 3 shows.

Figure 3: Attitudes to employing someone with varying mental health disorders



Source: Reavley, N.J., Jorm, A.F. (2011) *National Survey of Mental Health Literacy and Stigma*.



Attitudes to socialising have not shifted over the last eight years, as shown in Figure 4.

We know that such discrimination can play out in the small and daily interactions between people. These *micro-inequities*, where minor instances of discrimination or inequality are experienced repeatedly, build up to compound a person's experience of discrimination.⁷⁷ These experiences can even be felt coming from those who are supposed to be providing help.⁷⁸

This surely contributes to the fact that **65 per cent of the estimated 3.2 million** Australians who have experienced a mental health problem in the past 12 months have not sought help.⁴⁹

In one survey, 61.4 per cent of carers reported feeling that the health professionals treating the person they supported did not really understand what it meant to have a mental illness, while 31.3 per cent had seen the person they cared for shunned by health professionals when it was revealed they had a mental illness.⁷⁸

National and international research shows that discriminatory behaviours compound self-stigma, discouraging people from participating fully in treatment, with negative impacts upon their recovery and health.⁷⁸ They also withdraw from daily activities.^{55,76}



The early findings of the Commission's own pilot online survey found that 23.3 per cent of respondents said that social discrimination 'got in the way' of them feeling connected to family, friends, culture or community.¹¹

We also know that discrimination associated with mental illness extends to families⁷⁹ and can affect their own behaviour.⁸⁰ Misunderstandings of a family's role or responsibility can lead to negative attitudes which make family members feel discounted or ignored,⁸¹ and can inform how people outside the family react.⁸²

In one survey of support people:

10.6 per cent

of support people reported being **treated often or very often as "less competent"** by others when they learned they were a mental health carer

30 per cent

avoided telling people outside their immediate circles that they were a mental health carer

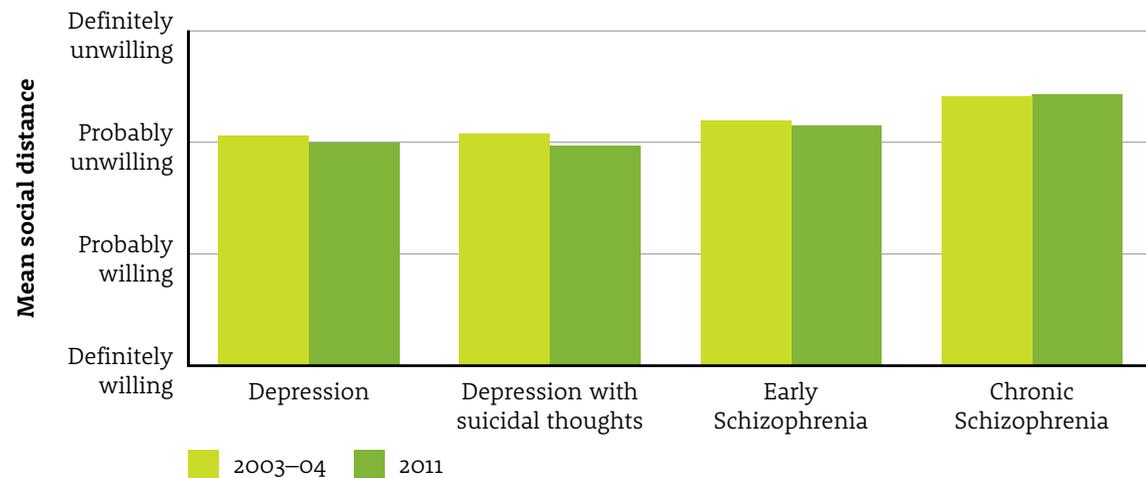
About 60 per cent

of respondents had **experienced negative, hurtful and offensive attitudes** from the public.⁷⁸

Discrimination and bullying – for example at work, or because of sexual orientation or race – contribute to poor mental health.⁸³ We know that young people who are bullied are at-risk of higher rates of poor mental and physical health and suicidal behaviour, which can carry over into adulthood.⁸⁴ In Queensland, of 63 youth suicides in 2011/12, at least three were directly attributable to bullying.⁸⁵

We know that the Australian media continues to play a powerful and influential role in shaping and changing attitudes through informed reporting.⁸⁶⁻⁸⁹

Figure 4: Reported desire to keep a social distance from people with selected mental illnesses



Source: 2013 National Mental Health Report

Experience of discrimination among Aboriginal and Torres Strait Islander peoples

Experience of discrimination is culturally variable

Social and emotional wellbeing and the impacts of racism

Aboriginal and Torres Strait Islander peoples describe their mental health as having a foundation of 'social and emotional wellbeing' originating in a network of relationships including those between the individual and their community traditional lands, family and kin, ancestors and the spiritual dimension of existence.⁹⁰ Life is understood in holistic terms: with the health of individuals and communities evident not simply by the absence of disease but linked to their 'control over their physical environment, of dignity, of community self-esteem, and of justice.'⁹¹ Respect for Aboriginal and Torres Strait Islander rights is fundamental to social and emotional wellbeing: racism and discrimination are associated with negative physical and mental health impacts.⁹²

The approach of 'social and emotional wellbeing' provides a less stigmatising description of mental health than the western culture's views, based as they are on formal psychiatric/medical definitions and concepts.

For Aboriginal and Torres Strait Islander peoples living with a mental health condition, a 'matrix of discrimination' (reflecting compounding and cumulative experiences of racial discrimination and stigmatising attitudes towards their mental health condition) can be particularly challenging. In practice, it may not be possible for such a person to identify precisely why they have been discriminated against, in any given situation.

Likewise, it will not be necessarily possible to separate out the existence of a mental health condition from the experience of racial

discrimination. Almost without exception, international studies find that racism and racial discrimination are associated with poorer mental health status^{93,94} – findings echoed in the eight studies on the impact of racism on Aboriginal and Torres Strait Islander peoples that have occurred to date.⁹⁵⁻¹⁰²

When discussing the stigma faced by Aboriginal and Torres Strait Islander peoples with mental health conditions, it is important that forms of discrimination are not viewed in isolation and that any effort to address stigma on the grounds of mental health acknowledges and incorporates Aboriginal and Torres Strait Islander people's lived experience of racial discrimination.

Experience of discrimination among Culturally and Linguistically Diverse (CALD) communities

Cultural attitudes and understanding

The diversity of peoples' beliefs, understanding and response to mental illness is shaped by their cultural heritage and experience. While a refugee's mental health may be affected by their experience of trauma in reaching Australia, their understanding of 'mental health' and that of their family and community will also reflect their heritage.¹⁰³ There is a broad diversity of understanding regarding the causes, expression and outlook for different illnesses. The Western model of mental ill-health is often felt to be inappropriate by many people and does not speak to their experience, which may be influenced by a combination of social, religious, biological, psychological and cultural explanations.¹⁰⁴

There is some evidence that there can be high levels of stigmatising attitudes in some CALD communities, as there can be in all communities. Some understandings of mental illness do link it to shame, humiliation and 'loss of face'. People from these diverse communities may have a different experience of mental illness,¹⁰⁵ be less likely to disclose symptoms, more likely to express distress in the form of physical symptoms,¹⁰⁶ and less likely to seek treatment which they may feel is inappropriate.¹⁰⁷

This is compounded by limited availability of inclusive services which can provide culturally sensitive interventions, services and interpreters.¹⁰³ Young refugees, adolescents in particular, are more likely to seek help from friends than from professionals because of stigma associated with mental health problems. A study of West African women living in Western Australia showed their feelings of shame or fear of being judged by others hindered their willingness to access health care services.¹⁰⁸

Creating cultural understanding

What it means for Antonia, New South Wales

As a Greek mother caring for two adult children, sharing my story as I tried to reach out for assistance and support has led to an ongoing process of healing and enlightenment, not just for me, but for other members of my community.

It's been 26 years now since my daughter's mental illness was first diagnosed. It was like hell and it didn't get any better when my son's mental illness was diagnosed a few years later. All my time and energy was taken up for them – organising help, negotiating with treatment services, getting them support ... or trying to. Even when I succeeded getting some help for them, the impact of the stigma and the chaotic lifestyle left our family struggling to survive. It never occurred to us that we deserved some help too.

I became involved with a Greek Carers' Support Group. I was frightened and anxious because of how I had been treated by other members of my community in the past.

People who I went to for support began to ask me to share my experiences more widely and I began to have requests from various groups to talk about my experiences.

The more my stories were heard the more opportunities there were. I am currently leading five Greek Carers Support Groups and I was awarded the NSW Carer of the Year Award in 2011.

Reaching out to others not only meets my needs but empowers you to help others to meet theirs. The more opportunities we take to share those painful episodes of our lives, the more we are empowered, and the more other people will feel encouraged to add their chapter to the story and gain their portion of healing.



Watch Antonia's video at www.mentalhealthcommission.gov.au



What the evidence shows is good practice

The evidence we have is inconsistent in quality and therefore in the reliability of conclusions drawn.

However, national and international studies suggest that longer term anti-stigma and discrimination initiatives have more success in reducing the experience of discrimination by people living with a mental health difficulty than short-term initiatives.¹⁰⁹

The main focus of investment in Australia since 1992 has been on broad mental health education and community understanding programs. Such programs may be successful for many people and have increased overall mental health literacy, but more targeted programs are needed for people who come into frequent contact with people with mental health problems, such as health professionals, police and workers in the justice system.

This is where Mental Health First Aid (MHFA), a training course based on person-to-person mental health education, has been effective in improving mental health literacy and reducing stigma all over the world. MHFA was developed in Australia in 2001¹¹⁰ and teaches people (18 years and over) how to provide initial support to adults who are developing a mental illness or experiencing a

mental health crisis. There is also a course for adults working or living with adolescents.

With its evidence of effectiveness supported by high quality evaluations and global uptake, this is an example of international best practice. For example, it has been found to be effective in workplaces and with CALD communities.¹¹¹



“We work with people negotiating their gender, sexuality and/or intersex status and have developed education and training programs aimed to provide clear messages about stigma and discrimination, and the impact these have on a person’s sense of wellbeing.”

Susan Ditter, Working It Out Tasmania

Only a relatively small number of initiatives have been evaluated. Evaluations of effective programs for Aboriginal and Torres Strait Islander peoples, as well as people from CALD communities, is complicated by the differences in understanding of mental illness between cultures and in the social acceptability of reporting symptoms.¹⁰⁴ And again, there may be good practice models in operation, but these have not been evaluated.

Policies for reducing bullying have been developed for schools and workplaces. Identifying where good practice lies may be in bringing together key elements – having involved adults at school, open discussion with established boundaries on acceptable behaviours, having leadership, clear bullying policies and expectations for behaviour that are implemented.¹¹²

“Public awareness of mental health needs to increase. At the moment I feel like it is a taboo subject in the community and it needs to be able to be talked about more.”¹¹

What we don't know

Where we need more evidence, and to shine a light

Mental health promotion and awareness programs have been rolled out across our country. Spending by states and territories on these programs alone came to \$16.4 million in 2010-2011,¹¹³ with grants to non-government organisations totalling an extra \$19.65 million.¹⁵



Despite this, the Commission is concerned that we have insufficient evidence to ensure that money is being spent in the most effective way. Some examples of gaps in our knowledge are as follows.

Studies of whole-of-community, anti-stigma interventions in Australia are of insufficient quality and number to allow conclusions about effectiveness to be drawn about what works.

There is also inconclusive evidence about school-based and tertiary education-based campaigns in improving mental health literacy of students.

We need to have a better understanding of why improvements in overall community understanding of mental health do not translate into equal levels of improvement in reducing discrimination and stigma.

We need to know why stigmatising attitudes and prejudice persist. To support this, we need to address our gaps in knowledge about why certain groups in our community hold more discriminatory views and attitudes, and what types of approaches are most effective in changing this.

“A person’s identity and sense of belonging are critical to building resilience and being a participating member of the community.”

Susan Ditter , Working It Out Tasmania

We do not fully understand the social and cultural factors that underlie stigma, or the ways in which it can be reduced and prevented.¹¹⁴

Further investigation is needed to identify how stigmatising attitudes arise and why they persist, and to generate evidence about what works to reverse them. There are many people who experience discrimination even without having mental illness. For those people – including refugees, people affected by drugs, different ethnic groups, people identifying as lesbian, gay, bisexual, transgender or intersex (LGBTI), homeless people, cognitively impaired people, and physically disabled people – developing a mental illness can exacerbate or even be a result of the experience of discrimination.

“In any community you get out of it what you put into it. Being in the community itself, the word community doesn’t exist if you don’t work with it and get involved with people.”¹¹

Creating healthy workplaces

What it means for Margo, Victoria

Workplaces are a logical environment for building a strong sense of community connectedness and belonging. They have a crucial role in at least protecting, and possibly promoting dignity and respect, security, integrity and autonomy of the person. They can serve the need to feel a part of a community in which there is respect for due process and fair procedures.

Employers who invest in understanding mental health issues and how mental illness or poor mental health may affect their staff are typically rewarded with a higher trust environment, improved morale and a more loyal and productive workforce. There are many simple and inexpensive ways to do this – team lunches, creating opportunities for collaboration across teams, workplace mentor and leadership programs and social club activities.

Another highly effective way to improve understanding is through specialist training about mental health. As well as basic management training for frontline managers and supervisors, training on mental health is an excellent way to increase the confidence and capacity of

managers. It assists them to identify someone who may be at risk and facilitate access to the right treatment, or to support someone experiencing mental illness in their recovery and return to work.

SuperFriend has seen this in the Industry Superannuation sector, where we facilitate tailored mental health and wellbeing training to superannuation and insurance staff. In an industry that can deal with members at stressful times, these sessions provide opportunities to build staff capability and improve member outcomes, decrease stigma about mental illness in the work and broader community, and lastly, benefit the staff teams with a greater shared understanding and an increase in team morale.

Employers are coming to understand the economic sense, as well as the social benefits of investing in their people's mental health and wellbeing. After all, good work is good for peoples' mental health, as it provides us with social interaction, a sense of purpose and sense of community contribution.



Watch Margo's video at www.mentalhealthcommission.gov.au



Spotlight issue

Attitudes underlying policies and programs



Discrimination towards people living with a mental illness can be overt or subtle.¹¹⁵

Of most concern to the Commission is any discriminatory process or behaviour, which limits the choices or opportunities of people living with a mental health difficulty.

Discrimination operates at both the institutional and interpersonal level.

Discrimination at the institutional level: 'structural discrimination'

The Commission is interested in two aspects of institutional discrimination.

The first is discrimination at work towards employees. For many of us, our workplace – where we spend many hours – provides an environment for meaningful occupation, social networks and personal reward. Discrimination at work can undermine both the benefits of work and harm our mental health. It can lead to loss of income, housing and financial independence.

Workplaces that tolerate discriminatory attitudes and behaviour, as well as bullying, are cultures that are no longer publicly tolerated. We see large employers, public and

private, openly redressing the problems of past institutional practices. Forty-two employers recently responded to the Mentally Healthy Workplace Alliance's call for good practice, giving real examples of what has worked and what hasn't.²

Our second concern is where policies or procedures explicitly, or more often implicitly, discriminate against people who experience a mental health difficulty. This may not be overt or intentional, but it still falls within the definition of discrimination under the *Australian Disability Discrimination Act 1992*.

It may reflect the lack of awareness of how the policy may unintentionally impact upon someone with a mental illness or not take into account the psychosocial disability that they may experience.

This may be most clearly seen in getting and keeping a job. We have heard from the Mental Health Legal Centre of Victoria that having a forensic psychiatric history directly affects job prospects¹¹⁶ and from the Australian Human Rights Commission that where psychosocial difficulties affect performance it can lead to dismissal.¹¹⁷

Barriers can also be posed by routine practices. For example, barriers to getting government housing start with the application process itself. One Australian study of 372 people with a mental illness who had applied for public housing found that 90 per cent reported difficulties with the complexity of the application process.^{118,119} Again, the *Disability*

Discrimination Act would require the housing provider to accommodate the person's needs arising from their disability.

Discrimination at the micro discrimination, interpersonal level:

Discriminatory attitudes in the workplace, for example, can affect recruitment decisions and therefore equal opportunity for meaningful work.

A literature review for the Mentally Healthy Workplace Alliance showed a tendency for employers and society in general to see people living with mental health difficulties as being incapable of engaging in employment.¹²⁰

To help people living with a mental health difficulty who, as a group, are already under-employed and unemployed at higher rates than the general population, we need strong workplace leadership, positive and open cultures and policies that are implemented.

This will help to ensure that employers:

- do not have lower expectations of people with health problems, but put measures in place to ensure that they have the same opportunities as others; and
- acknowledge that living with a mental illness does not necessarily affect a person's capabilities or capacity to work or make decisions. While illness may affect a person when they are unwell, under Australian law employers are required to be flexible in accommodating their health needs as for any other illness.

Where the Commission is looking for continuous improvement

We know that improvements in community understanding have not been paralleled by a reduction in discriminatory behaviour and attitudes.⁷² The Commission looks to ways to push ahead in improving those areas most impervious to change.

We therefore call for a sustained national strategy for reducing discrimination. This needs to be multi-faceted and deployed at the community level. It needs to feature evaluation from day one. It should target groups we know remain resistant to improvement, who are in frequent contact with people with mental health problems and their supporters, and where we can make the biggest impact on attitudes and behaviour.

The benefits that can be gained from a sustained reduction in discrimination are measurable – and we look to national indicators to do this. There is a potential return on investment from this approach that needs to be universally acknowledged. The benefits will accrue on the personal level, at the family and community level, and across our nation in workplaces and schools.

The Commission looks for improvement in specific areas:

As **stigma from health professionals** is an area of significant concern to people living with a mental health difficulty and their support people, we need to tackle this as a priority.

There is also a clear need for approaches to address mental health literacy and stigma in **Aboriginal and Torres Strait Islander communities**. These must be culturally appropriate and developed and driven by Aboriginal and Torres Strait Islander peoples, to reflect their culture, history and social approaches to mental health and wellbeing.

We must also not forget the need for improved mental health understanding across **CALD communities**, and for cultural diversity to be reflected in practice.

Research shows that **discriminatory attitudes vary with particular mental health conditions**. Further work should address mental health literacy and stigma reduction, particularly in relation to schizophrenia. Some of the most discriminatory attitudes are directed at people living with this illness, yet it is one of the least prevalent mental health conditions. Similarly, we must continue to challenge some persisting misconceptions about the more common mental illnesses, such as anxiety disorders and depression.

In all efforts to reduce discrimination, we must **incorporate the voices of people** with experience of mental health problems and their families and support people. Their expert feedback can help to create more responsive and higher quality services and can be especially powerful to drive attitude change.

In a human service organisation, the lived experience of people with mental illness and their families and support people is directly affected by the **skills, attitudes and behaviour of staff**. Staff who have clear objectives and well-structured appraisals are more likely to report they are engaged in the work of their organisations than those who do not. Engaged staff are those who are well led, with the leaders of frontline teams having a particularly important role in creating a climate for changing attitudes.

We will not make a difference to peoples' lives unless we are all prepared to stand up against discrimination wherever we may witness it.

The Commission believes it is time to positively discriminate in favour of people living with a mental health difficulty. We believe that just improving understanding of mental health issues in the community is insufficient. It is only by starting with our everyday interactions, within our families, schools and workplaces, that we can foster behaviours which are inclusive. If people feel more included, they are more likely to seek help when it is most effective.



Ensuring effective care, support and treatment:

Approaches that support recovery, including early intervention

Lachlan, South Australia

The difficulty with having a mental illness is sometimes you don't even know you're sick. When I was first admitted to hospital, I didn't understand the extent of my symptoms. I was experiencing a psychotic episode, and was diagnosed with Schizoaffective Disorder.

Even now I'm still not sure if it's really what I suffer with, but I take the medication anyway. I know the drugs are not harming me; maybe I don't want to admit to myself that they help me get through.

I had to tackle my mental health issues and found a local activity program. When I started I felt alone, misunderstood and confused. I forced myself to come every day. Soon I realised it was part of my routine and something I look forward to.

I now know it has a positive effect. All participants attend the program as part of their recovery journeys. We share our experiences with illness, symptoms and medication and support each other. This reminds me that I am not alone, that others have experienced similar things. I now support others which has increased my self-esteem and confidence.

I began to look towards the future and set recovery goals. Seeing my goals and achievements written down gave me confidence and hope. I was very surprised at the number of good things in my life.

My self-esteem and confidence has skyrocketed. I'm now living independently, which has been a massive step in my recovery. I've also reconnected with my church and my lacrosse club. This has been so important as I'm once again involved with a sport that I love. I have been accepted by the members of my former club and encouraged to join in with club community events and to take up playing again.

I now know it's important to have goals and plans for the future and to work hard to achieve them. I'm very proud of myself and how far I've come in my journey.



Watch Lachlan's video at www.mentalhealthcommission.gov.au

Introduction

The ability to lead a contributing life is everyone’s right, whether or not they experience mental health difficulties. Access to timely recovery-oriented support, both at the emergence of illness and throughout life, is vital if we are to uphold this right for those who do live with mental illness and those close to them.

Recovery is a journey which is unique to each person living with a mental health difficulty, and their families and support people often travel alongside them. The journey does not have a defined end point, but develops and evolves as the person continues on their life’s path. People can begin this journey whatever their age or stage of life – whether this is when illness first emerges or at any time a person feels it is right for them.

What ‘recovery’ means is different for each person, and each person must be supported to define it for themselves.

We asked people in our National Contributing Life Project pilot surveys what helped and what hindered them in living a contributing life.

The three most important things that have emerged from the early findings are:

- 1. relationships and connections**
- 2. stigma and discrimination**
- 3. a sense of personal control, including having enough money**



The Commission supports the definition offered in the recently released *National Framework for Recovery-Oriented Mental Health Services* that recovery entails:

‘...being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues.’¹²¹

Recovery and a contributing life are inter-twined – you may have recovery goals in place but poor physical and mental health, job redundancy or eviction from your home all hinder progress towards those aspirations.

Therefore the Commission believes that incorporation of a whole-of-life perspective into any recovery approach is essential, as is intervening as early as possible.

Getting help early when things are going wrong is vital.

We know that 75 per cent of all cases of mental illness will occur by the time Australians reach 25 years-old.¹²² When

What’s important in having a meaningful life?

“Feeling like I am making a difference and achieving something good”

“Having a purpose and a healthy self-identity”

“Being valued by others”

“Having friends and the belief that there is more opportunity to have more friends in the future”¹¹

you’re young, the onset of mental illness disrupts every facet of your life – school, family, social life and job prospects – and your future potential.

This chapter takes a wide perspective on recovery, in its broadest meaning and the opportunities it brings for a contributing life for all people. It spotlights two effective means of support, care and treatment:

1. We look at early intervention and what this promises for our young people, in particular through integrating clinical support with other life needs
2. We look at how the lived experience and expertise of peer workers can offer hope in supporting the recovery of others.

What we know

We know that life and circumstances can put barriers in the way of a contributing life. Being able to live a contributing life is not just about having mental health-related recovery goals in place, but can also be about having something meaningful to do and connecting with people.

These goals are unlikely to be achieved by a person who is experiencing poor physical health, has just lost their job, or who has been evicted from their home.

Since 2009, the adoption of recovery approaches by mental health services and community organisations has been a priority for action under the National Mental Health Plan.¹²³ We know that every state and territory has the concept of recovery embedded in their strategies or service plans.¹²⁴

The 2013 *National Framework for Recovery-Oriented Mental Health Services* highlights three characteristics for every service. Such a service:

- ‘recognises and embraces the possibilities for recovery and wellbeing created by the inherent strength and capacity of all people experiencing mental health issues
- maximises self-determination and self-management of mental health and wellbeing, and
- assists families to understand the challenges and opportunities arising from their family member’s experiences and recovery processes and how they can assist in their recovery while also helping them with their own needs.¹²¹

Early intervention is a term mostly used in the context of working with children and young people. This is logical, because this is the period when illness often begins to emerge and where interventions can be especially effective at mitigating the direct impacts of symptoms, and avoid later difficulties.

Early intervention can involve connecting with people as they start their families, throughout pregnancy, and in early childhood.¹²⁵ The first few years of a young person’s life are crucial in setting the scene for the rest of their life.¹²⁵ A child who lacks stimulation or who is exposed to chronic stress can find it extremely difficult to overcome a tough start.¹²⁶

We know that successive governments at a national and state level are investing more in early intervention approaches for young people. Nationally we are seeing a range of early intervention services: *headspace* centres and *e-headspace*, early psychosis intervention services, online supports and games such as *ReachOut.com*, *Bite Back* and *SPARX*, and initiatives targeting schools and universities, such as the *Schools Early Action Program* in Victoria and Batyr.

We know that the best models of early intervention will feature working holistically and proactively with the person and their support people to both avert the progression of illness and reduce the severity of symptoms. Best practice will pick up on early warning signs when things start to go wrong and provide non-stigmatising approaches.¹²⁷

We know that there is a great need for earlier intervention for people of all ages who are experiencing mental health difficulties for the first time or who have recently experienced a worsening of their mental health issues. We know there are serious consequences of not intervening early – these are most notably seen when a crisis occurs and potential economic, accommodation and employment impacts for that person are highly likely.

There are many clues that our support services across health and housing sectors are all too often reactive and crisis-driven rather than focused on intervening early.

Early findings from our *Contributing Life Project* give some evidence of a current lack of emphasis on early intervention.

These give us a small insight into the detrimental impact this can have on people's everyday lives. The second answer below also shows that early intervention can simply mean thinking ahead and providing follow-up, so that further crises could be prevented.



What could have been done to improve the support you received?

“Not having to go to the general emergency department ... If I am not able to be in hospital, then give me an adequate alternative and validate the fact that I have come to the emergency department out of desperation – not because I want attention.”

“Maybe a mentor or a support person who can come into the hospital/system and give more 1:1 support ... little supported outings – not just thrown back out there after a long stay, bag in hand and an appt. with psychiatrist 2 weeks away.”



Rates of mental health-related Emergency Department (ED) attendances by those experiencing a mental health crises have not improved over recent years.¹²⁸

Levels marginally shifted in the five years to 2010-2011, when there were an estimated 243,444 ED attendances by people with a mental health-related primary diagnosis. This finding reflects gaps in the system of supports accessible to people in the community, and in the ability of services to reach out to, or follow up, those who are vulnerable.¹²⁹

During the four years to 2010-2011, **the numbers of people who accessed accommodation services due to being homeless or at risk of homelessness because of a mental health problem grew by five per cent each year.**¹³⁰



Again, this is not heading in the direction in which we wish to see change.

We are told that Australia is lagging behind other countries in its recognition and employment of peer workers. The evidence suggests that the peer workforce offer a number of benefits, including reducing the rate of hospital admissions for the people with whom they

work.¹³¹ In the USA, peer workers are certified professionals, and the Centre for Medicare and Medicaid Services recognises peer support providers as a distinct provider type, and considers this an evidence-based model of care.¹³²

Spotlight issue

Early intervention for young people



While early intervention is important at all stages of life, the Commission recognises how vital it is that services are available to support young people at the onset of mental health difficulties.

We know that more than half of those in the general population who are experiencing mental health problems are reluctant to seek help, and this is even higher among young people, especially males.⁴⁹

Some studies have reported that delays in seeking treatment for first episode psychosis have been found to range from an average of one to two years.^{133,134} Such delays are unacceptable, because we know that people living with untreated mental illnesses can have a delayed response to treatment commenced at a later stage, which in turn impacts on their ability to lead a contributing life.¹³⁵

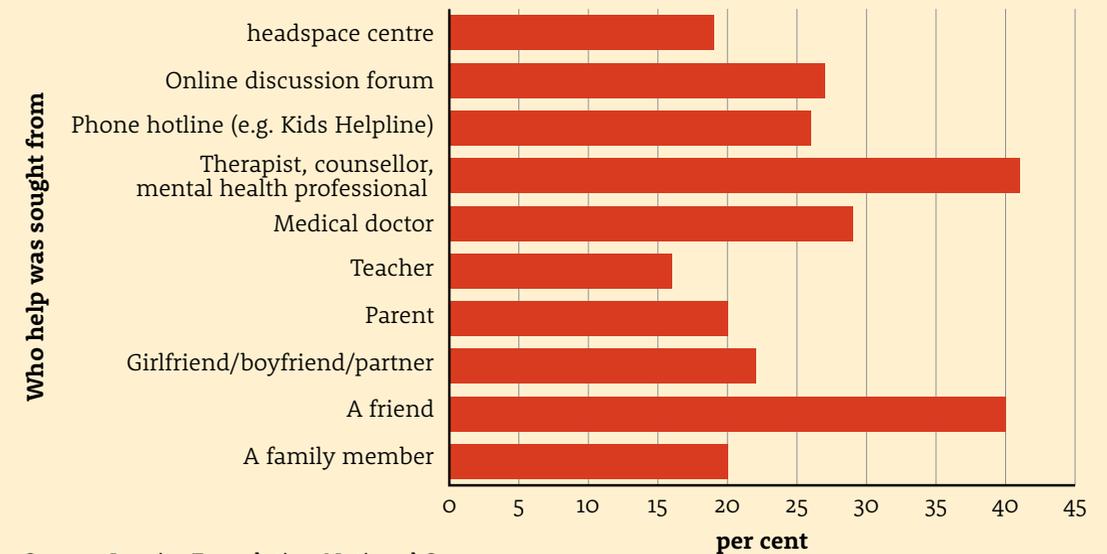
We know that for young people, the first point of contact in a crisis will not necessarily be either with mental health or targeted early intervention services.¹³⁶

The *Young People in Custody Health Survey*, conducted in New South Wales in 2009, found that 87 percent of young people in the juvenile justice system were found to have at least one psychological disorder.¹³⁷ Youth homeless services and helplines such as Kids Helpline report that 48 per cent of contacts by young people experiencing homelessness accessing this service also experienced suicidal thoughts or self-harm.¹³⁸

The responsibility to intervene to help young people does not lie within the spectrum of health services alone but is the responsibility of all sectors.

Early intervention for those aged 12 to 25 years can mean avoiding massive upheaval during these formative years, which can have lifelong impacts. Studies show that the deterioration in the life chances of people with psychosis does not come just from their disturbing symptoms, but broader psychosocial disruption: educational interruptions, loss of relationships, and stigma and identity struggles affecting personal development.¹³⁹ For example, workforce participation is

Figure 5: Where young people experiencing high or very high psychological distress are more likely to go for help



Source: Inspire Foundation National Survey 2012.

particularly low among people experiencing mental illness, as is average household income in adulthood compared to the general population.^{140,141}

There is some clinical debate about at which age or point in time that medical treatment should be offered to young people with mental health problems.¹⁴²⁻¹⁴⁴ Ongoing research and evaluation of early intervention services for young people are crucial.

The *National Survey of Young Australians* showed that a high number of youth (37 per cent) and Aboriginal and Torres Strait Islander youth (26 per cent) accessed the internet for advice.¹⁴⁵ Internet self-help programs for young people are a growing area of interest, with a number of online self-help resources for young people currently available.

We know from a 2012 cross-sectional study by *ReachOut.com* of 3,682 young

people under 25, that after going online, young people who had high or very high levels of psychological distress are more likely to then seek help (refer Figure 5). They said they would go to a mental health professional (41 per cent), a friend (40 per cent) and a medical doctor (29 per cent).¹⁴⁶ This reinforces that early intervention services need to be designed in collaboration with young people, and regularly seek their feedback.

Getting support for your daughter

What it means for Cecilia, Victoria

I came to Australia from Chile in 2000 with my two daughters. When my oldest daughter had her first schizoaffective episode at 16 years, I decided to take her to a youth centre. I could speak only a little bit of English, so it was very difficult to explain what was wrong. The staff recognised she was unwell and helped us straight away. Shortly after she was hospitalised for a while.

I quit my job in order to take care of her. Her illness pushed me to learn English and pursue further study, so that I could understand her mental illness. My daughter came to classes with me because she was fearful of being alone.

My caring role affects my personal relationships because people don't understand my daughter's illness, and why I have to leave suddenly in order to help her. In addition, the relationship with my younger daughter has been affected. Even though she understands her sister has a mental illness, she resents that I can't spend more time with her.

I still worry about my oldest daughter. I never know when her symptoms will reappear. She is doing well and managing her medication, seeing a psychiatrist and a psychologist, and she is aware that she must manage her illness in order to live the life she wants to live (like any chronic illness). She lives independently with her partner. We catch up on a daily basis and she calls me any time she feels she needs it. We are a team.

I cannot explain the emotions I felt caring for my daughter when she was unwell. I don't know how I did it. But good things can happen. It pushed me to learn and develop as a person. When a door is closed, a window is opened.

 Watch Cecilia's video at www.mentalhealthcommission.gov.au



What the evidence shows is good practice

Good practice models of recovery and early intervention reflect the World Health Organization's view that policy and practice should not be solely concerned with mental disorders but also recognise and address the broader issues that promote mental health.¹⁴⁷



The Commission has therefore looked to good practice across different settings.

We believe that good practice incorporates the direct involvement of people living with a mental health difficulty and their support people. The supports offered must be sufficiently flexible, not only to meet the specific needs of a range of groups, but also to respond to the changing needs of individuals as they move along their recovery journey.¹⁴⁸

Achieving this requires close collaboration of government and non-government supports in a range of areas. It requires the development of integrated models of care that address the full range of factors affecting mental health and wellbeing – such as education, employment and housing. It must also be evidence-based and outcomes-driven.¹⁴⁹

The Commission is aware of a number of approaches in Australia which demonstrate a pro-active, early intervention approach to supporting recovery journeys for adults. These also demonstrate collaboration between public, private and not-for-profit agencies, and between education and employment providers, housing, health services, and organisations working for social engagement.

One example is the 'Platform 70' Project, a joint initiative of Bridge Housing, Neami National and St Vincent's Hospital Sydney to deliver housing, mental health and health services to 70 people 'sleeping rough' in the City of Sydney. In March 2013, it was reported that a number of participants had started further education, had begun to address their substance use problems, commenced work and re-engaged with their families.¹⁵⁰

In the UK, *New Horizons strategy (2009)* and *No health without mental health: A cross government mental health outcomes strategy for people of all ages* have generated a philosophy and practice of joint working between government departments and between government and non-government organisations in that country.¹⁵¹

In the US state of Texas, mental health services are being integrated within a broad public health and early intervention approach incorporating housing, employment, technology, justice and child and adolescent services, among others. This initiative is being implemented in steps, beginning with demonstration projects which are evaluated to provide ongoing learning and measurement of benefits.¹⁵²

In Australia, *headspace* is based on a collaborative approach to early intervention in youth mental health. Funding has just been committed for a new *National Centre for Excellence in Youth Mental Health* to discover and translate new evidence-based treatments, and develop and support a new workforce for expanding frontline services and maximising outcomes.⁷

The World Health Organization recommends a 'whole of school' approach to early intervention, based on evidence that this is more effective than topic-based interventions within the curriculum.¹⁴⁷

Co-ordination and communication between schools, families and services are essential to a whole-of-life early intervention approach. Often parents or teachers can be the catalysts for accessing timely support. An example of such an approach is the *Got It!* initiative in New South Wales.¹⁵³ This targets children in middle childhood who are experiencing behavioural problems, working to keep them in school.

“I think there should be some more mental health services available for young people over 18 who I still consider to be children. Also there needs to be more education in schools, especially earlier on.”¹¹

In focus: Peer work

The Commission feels strongly that the peer workforce must:

- be an essential component, not an ‘add on’ to any support team, with equal status to their team colleagues
- be remunerated appropriately at a level commensurate with their skills and training – a good and willing volunteer is just that, not a peer worker
- be supported and sustained into and in the role with high-quality, ongoing training and supervision
- be supported by national competencies and standards, and
- have a clear career trajectory.

Mental health peer workers are in paid roles that require them to bring expertise to their position based on their lived experience of mental illness, either personally or as a family member or supporter.

Peer work can take many forms; from giving hope and modelling recovery to contributing to the recovery of people and their families, by providing social support, advocacy, and one-to-one mentoring.^{154,155} Approaches are flexible and peer workers can address aspirations and

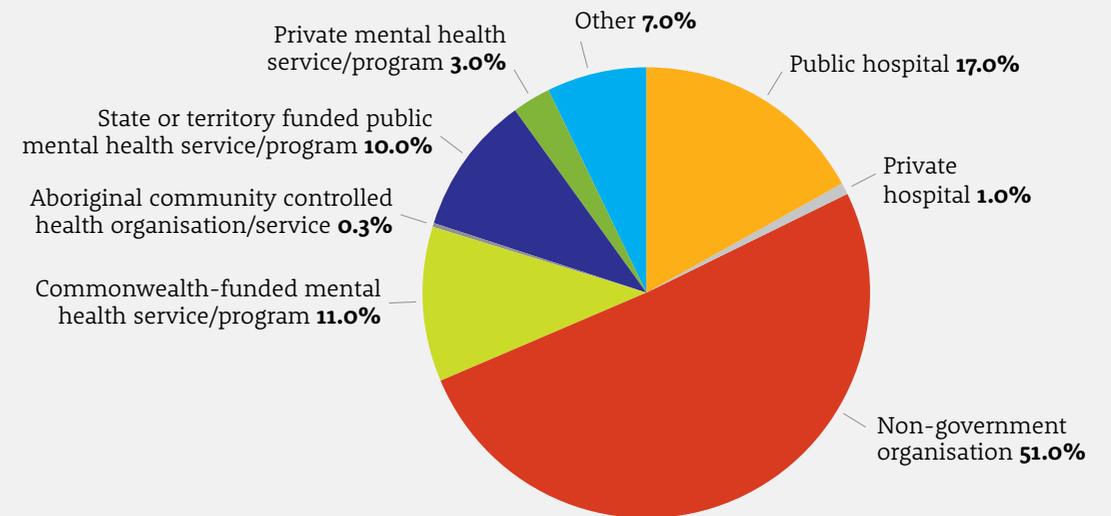
personal goals, rather than focusing on medical treatment. Family peer workers play a crucial role in offering others support and advice to navigate through the mental health system and advocate for change.

Evidence on the major benefits of the peer workforce to mental health outcomes and recovery has developed rapidly in the last decade, with some seeing their employment as “one of the single most effective ways to develop and sustain a culture that stays focused

on recovery practices.”¹⁵⁶ They can influence and change service culture and practice, and bridge gaps between supports provided by other professionals.

The benefits of having a peer workforce include reduced social isolation, increased service access for substance use and health difficulties, improvements in social functioning, enhanced empathy and acceptance, reduced stigma and an increased feeling of hope.¹⁵⁷

Figure 6: Mental health peer workers by service type



Source: Health Workforce Australia 2013 (Unpublished)

Peer workers can bring about positive change in the culture and recovery focus of the organisation in which they work; for example, with colleagues becoming more aware of the language they use.^{158,159} Evidence suggests that peer workers can also help to reduce the use of seclusion and restraint.¹⁵⁶

The peer workforce can provide a meaningful career option for some people living with mental health difficulties.¹⁶⁰ The available research evidence indicates that peer workers perform at

least as well as other staff in areas such as reducing hospitalisation rates, accessing hard-to-reach clients and reducing levels of substance use.^{157,160-162}

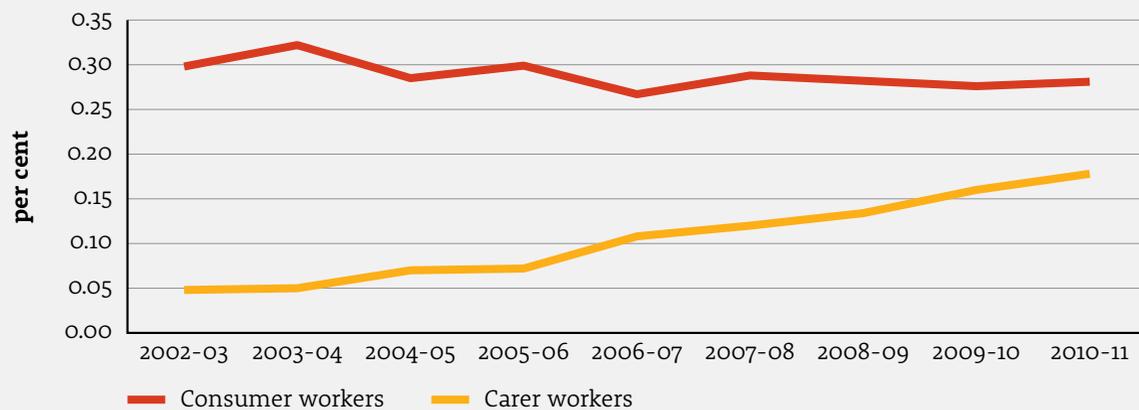
While the benefits of peer work have long been recognised in the addiction field, the peer workforce is now the most rapidly growing workforce in the mental health sector in Australia, with many working in the non-government sector (refer Figure 6).

Recent research undertaken by Health Workforce Australia included a small-scale survey of 305 people who identified as peer workers. Of this sample, 18 per cent worked casually, 29 per cent full-time and 53 per cent part-time.¹⁶³ About half of the sample worked for non-government organisations, while 17 per cent worked in public hospitals, 11 per cent in a Commonwealth-funded mental health service or program and ten per cent in a state or territory funded public mental health service or program.



In focus: Peer work continued...

Figure 7: Consumer and carer peer workers as a proportion of the direct care mental health workforce



Source: AIHW Mental health services in Australia 2013

As peer workers can be employed under various titles and awards, further research is needed before we can have a complete picture of the numbers and characteristics of the Australian peer workforce.

Although these professionals have been employed in some Australian states for many years, the actual numbers of full-time positions in public health services remains very small and has increased very little over time (Figure 7). In practice, many are employed for just a few hours a week, and misunderstandings about the role and value of peer work still prevail.

Figure 8: The concept of recovery



Source: A national framework for recovery – oriented mental health services: Policy and theory. 2013

The endorsement of the *Certificate IV in Mental Health Peer Work* by the National Skills Standards Council provides a solid foundation on which to expand the peer workforce across all domains of a contributing life. The Commission is sponsoring Community Mental Health Australia to undertake the Peer Work Qualification Development Project¹⁶⁴ to develop training and assessment resources for both the consumer and carer peer worker streams.

The study by Health Workforce Australia gives us more information about the profession.

We now need to build upon the evidence and this momentum with some real action. The Commission calls upon all governments to together develop a National Mental Health Peer Workforce Development Framework and include peer work approaches as a key performance indicator for service contracts and programs.

We also endorse the call for a national target for peer workers in mental health-related support services. This target aims for 50 per cent of services employing peer workers in four years and 100 per cent in ten years. These actions will help to improve outcomes, and employment rates of people with mental illness and their families and supporters.

Using lived experience to help others

What it means for Judi, Western Australia

I gave birth to my son in 1984 and became overwhelmed and anxious in the most debilitating way. These feelings were not something I had ever dealt with. I was a professional, successful woman.

I knew I was not coping as a mother and trying to find answers for how I felt led me nowhere. I felt even more convinced that I had good reason to keep my feelings veiled. My son was aged just 4 weeks when I decided to go back to work. I knew the decision was a sacrifice that had changed me to the core and the trauma was deep and resonated for many years to come.

Eleven years later, I had another child. The self-blame started on her delivery. I met a nurse at a sleep clinic who told me I was not alone. She really cared that I was finding being a mother so difficult. This empathy changed my outlook. I felt validated and hopeful.

At a local peer-led support group at the hospital, I talked about my experience with postnatal depression and anxiety. This helped me heal and I started to recognise my own resilience.

One year later I was facilitating the support group as a volunteer and had started a psychology degree and a psychotherapeutic qualification.

I became a volunteer with a Post Natal Depression organisation and eventually became Vice President three years later.

In 2010 I developed and delivered a program called Making Sense of Motherhood. I continue to co-ordinate and facilitate this course, designed to support and enhance the relationship between a mother and baby.

The program and the marketing material have been sensitively developed to encourage women to speak up and seek help. They contain information that I would have found most useful had it been available during my time of need. A woman who calls or is referred to the service, speaks directly to me.

My life has been changed by my lived experience. Every single aspect of my work draws on the experiences I had throughout my journey. I believe peer health workers and peer mental health workers have the skills to support ourselves and others through their own resilience and recovery.

 Watch Judi's video at www.mentalhealthcommission.gov.au



What we don't know

Where we need more evidence and to shine a light

There is a lot we don't know. We don't know about equity of access to early intervention approaches, or whether we're reaching those most in need of early intervention.

We do know there are priority areas that we need to shine a light on.

While early intervention is intuitively important within a recovery approach, the actual evidence base for its effectiveness with children and young people in Australia is very limited, and based mainly on research assessing the impacts of early interventions for psychotic disorders.¹⁶⁵ In general, evaluations of early intervention approaches have only generated data on short-term outcomes, and there is a pressing need to monitor their longer-term impacts on mental health and wellbeing.

We also know little about the relative effectiveness of different forms of intervention. We don't know enough about the impacts of whole-of-school programs in Australia – we need to better understand why some schools have not adopted *KidsMatter* or *MindMatters* to help reduce the risk of mental health difficulties in the school community.

So far, the evaluations of early intervention programs are in their infancy and have focused mainly on implementation processes and activity. With significant new investments in this area, we need to take evaluation seriously. We need adequate outcome baseline measures and to track improvements to mental health over time.

We need to continue to investigate the ways in which new types of interventions – online and mobile therapies, blogs and virtual communities, games and applications – are being used in practice by people across the age-range and ensure they are effective in supporting a recovery-based approach.

We don't know much about help-seeking behaviour for mental health problems by young people and adults from CALD backgrounds.¹⁰³ The Commission has heard that both CALD communities and Aboriginal and Torres Strait Islander youth continue to have a very high level of unmet needs and in the first instance will often seek help from a family member or community

leader, rather than mainstream health services. The widespread use of universal approaches to mental health literacy may mean that groups known to be at high risk of mental health difficulties are not being effectively supported.

We need to consider our early intervention approaches for adults, at all ages and stages. Best practice models should support the person within their community and avoid further deterioration and the subsequent need for acute or crisis care. We need to know why people are not receiving the right treatment the first time they ask for help.¹⁶⁶

Families, friends and support people play a key role in supporting a person on their journey to recovery. This can come at a cost, with relationships becoming strained, financial stress and many supporters' own mental health deteriorating. We don't know enough about what families and support people need to recover from what can sometimes be a frustrating and exhausting experience of caring for a loved one and navigating their way through a maze to reach mental health supports.

Where the Commission is looking for continuous improvement

We know early intervention is a must for young people and should be a right for all people. This means acting at the earliest sign of a problem and the earliest days of an illness.

Early intervention and recovery are not new ideas. The Commission is aware that translation of these models into practice still has a long way to go.

Initiatives that take into account all of the needs of a person, including their mental and physical health, are good investments.

We look for the systematic evaluation of early intervention programs – we need to know if they are making a real difference. We need continuous improvement in the quality of information on their outcomes and reach. Equally, we need to hear about the experiences and views of people and their supporters who are using early intervention services. The Commission calls for such evaluation to be adequately resourced, and also to examine barriers to implementation.

We know something of the type and amount of intervention that is required to prevent the onset of mental health problems in young people. This is a rapidly expanding area of research and the Commission welcomes increased expertise in this field.

There are areas where further gains in mental health and wellbeing can be achieved, particularly among young Aboriginal and Torres Strait Islander peoples, people from CALD backgrounds, people in regional and remote areas and those experiencing socio-economic disadvantage. The Commission is looking for further research to show what works for these groups and their families and what the barriers are to seeking support.

Promoting and enabling recovery is the responsibility of schools, workplaces and communities as well as mental health services. We welcome further action in this area and recognise progress has begun.

We need to better understand why only some Australian schools have adopted universal school programs, and how to support educators to extend their uptake. We also look to further development into their impacts.

It is crucial that we continually re-evaluate and refine Australia's approach to early intervention in the light of emerging findings about successful practice.



Something meaningful to do:

Transitioning from education to independence

Mark, Northern Territory

Transitioning from primary to high school was difficult and stressful for me. My parents were going through a divorce and I had no support at school. I didn't seek help as I wasn't aware that I was developing the early signs of a mental health issue.

No-one stopped to ask if I was OK. There was no education on mental health at school. I believed you only visited the school nurse if you had physical symptoms.

I moved from Darwin to Brisbane to attend high school and experienced racism and discrimination, so I moved back home.

As a young man and one of the eldest in my family I felt I couldn't show my emotions – I had to be strong even if I was struggling to cope.

I left school for a full-time apprenticeship; however, racism and discrimination again forced me to leave. I spoke to my GP and was diagnosed with Anxiety and Depression. This made sense to me and I could start to understand my symptoms.

At 18 I set myself a goal and through the Northern Territory Indigenous Employment Program I completed a Certificate II in Business. I felt very proud and had a real sense of achievement. I was encouraged to apply for Indigenous Leadership Programs and although I still had doubt, I completed another two Certificate II level courses.

I was asked to give a speech on my experiences and was given the honour of Ambassador for the Northern Territory Indigenous Program.

Both my parents are affected by stolen generation issues which also impacts on inter-generations. In the NT, families are affected by alcohol and drugs, and there is a lack of good role models.

I have an opportunity to inspire a new generation. I talk with young people and promote good physical and mental health. If you set a goal and keep working towards it, you can achieve.



Watch Mark's video at www.mentalhealthcommission.gov.au

Introduction

All of us go through periods of change and transition in our lives. Successful transitions can set us on the path to a contributing life. Or transition points can present us with challenges which may increase our vulnerability to mental illness.¹⁶⁷

Transitions during childhood and adolescence are especially frequent and significant. They encompass rapid physical development as well as changes in social role and identity.

Most young people are resilient and adapt well to these changes. But this is also a time when significant mental health difficulties start to emerge. Nationally, about 26 per cent of people aged from 16 to 24 have experienced a mental disorder in the past 12 months.⁴⁹

If a young person begins to experience difficulties with their mental health, it is vital that they are supported by significant people in their lives to successfully navigate periods of difficulty – especially during transitions. This can help prevent knock-on

effects which limit future opportunity, such as disconnection from friends and from education. It can also help maintain engagement with the things they like to do and that give them a sense of satisfaction. Experiencing mental health difficulties must not mean compromising later life chances.

We focus especially on the role of the education and training sector in supporting young people, because most young people are involved with schools or colleges and spend a lot of time there during their formative years.

We recognise that successful transitions through education are not just about young people themselves – educators and families also need support to play their role.

Although we focus here on young people and transition points, the Commission believes that learning opportunities should be available to all ages. Education and training are vital tools to enable people at any stage to build on their strengths and to connect with their community.

The Commission sees fostering positive educational experiences and outcomes – whether through traditional or alternative pathways, and whether during youth or later in life – as the foundation upon which a contributing life can be built. Moving towards independence does not just mean moving out of the family home and gaining economic independence; it means the ability to make positive choices to shape one’s own version of a contributing life.

What we know

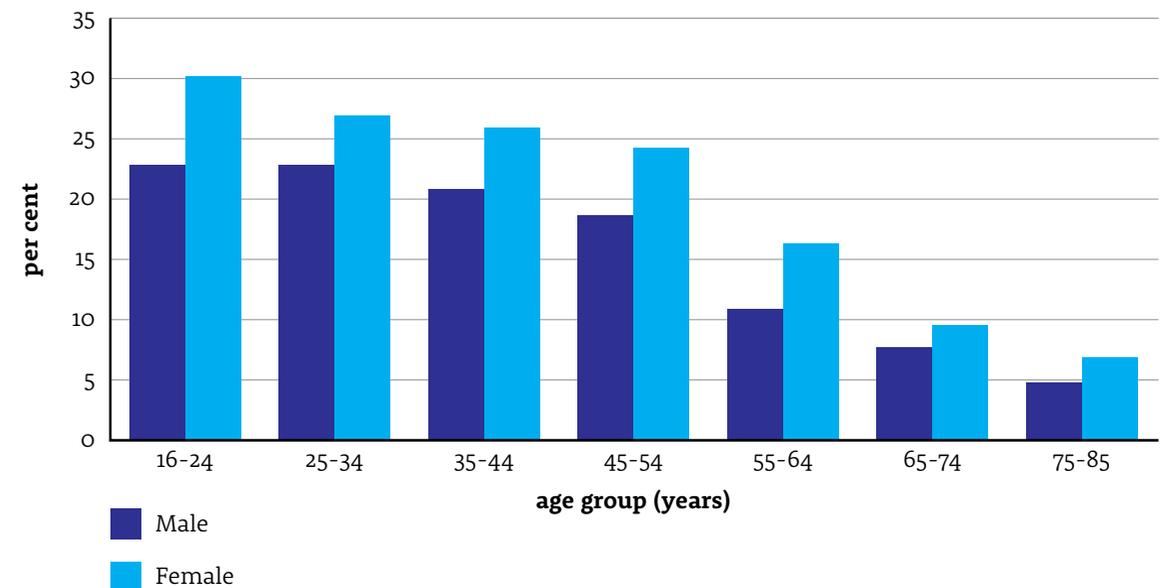
We know that not everyone has a start in life that is free of difficulties and there are times when children, young people and their families need support, especially at points of transition. People who are also experiencing mental health difficulties will find these transitions more challenging.

Therefore to boost their opportunities we know we have to support young people to traverse these points of transition successfully. In being successful we have first to listen to what young people themselves say works for them.

We could catalogue the multitude of statistics about the challenges and problems young people face. We know it is well documented that mental health difficulties can arise during adolescence, where dropping out of school,

bullying, experimenting with drugs, family discord and relationship breakdowns will be a reality, and that this can be the start of a life of disengagement and disadvantage.¹⁶⁸⁻¹⁷²

Figure 9: Prevalence of mental disorders by age group



Source: ABS National Survey of Mental Health and Wellbeing 2007

“I’d like to learn more about helpful coping strategies, healthy lifestyles, and helpful things to challenge and change your thinking in a positive and healthy way.”¹⁷³



“When you come to school it’s not just so you learn, it’s so you get ready for when you leave school and you have friends and people to talk to, and stuff – and your teachers.”¹⁷⁴

“For example, services might want to take into account that young people are more likely to seek help from an online forum than a phone helpline survey, but that face-to-face help from friends and professionals is still preferred over asking for help on Facebook or Twitter.”¹⁷⁵

“I feel normal – and like – there are other people going through similar things. I don’t feel alone about issues.”¹⁷³

“PDHPE teaches certain aspects about what they [illnesses] are. It’s about the illness – not about how you can help, or the next step.”¹⁷⁵

“If there had been someone around to help me when I was a teenager caring for a mentally ill mother I do think my life would have been so different ... I had some good teachers at school who knew that things were bad at home ... I didn’t need a school counsellor. I needed support and practical assistance to help with things like school books & uniform, a safe place to study.”¹¹

These statistics are about illness, disadvantage and roadblocks. Behind the statistics, though, there is always a young person with an experience.

We know:

- that young people consistently say that it doesn’t help them to always be hearing negative messages about the problems of growing up and mental illness, and
- that children and young people often have the best knowledge about what helps them maintain good mental health, and what makes them feel sad or under-valued.
- the lack of positive stories and emphasis on problems increases stigma and perpetuates the view that people who experience mental health difficulties cannot participate fully in society
- too much ‘education’ about mental illness as a subject rather than a broader integrated approach to maintaining mental health at school doesn’t help students help others or know how to help themselves¹⁷⁵
- young people believe good relationships – with family, teachers and peers – to be the most important ingredient in feeling good and mentally healthy.¹⁷⁴ A positive relationship with educational attainment – whether academic, sporting, creative, technical or vocational – acts as a foundation for better life and mental health outcomes
- young people who live in rural or remote locations, those who are negotiating their gender, sexuality and/or intersex status, or who have caring responsibilities for parents with a mental health problem, have particular needs.

We have heard from young people that:

- they want more positive messages in schools and in the media about it being possible to have a meaningful future, both after and while experiencing mental illness
 - they value role models and youth ambassadors who can tell their own story of recovery
 - for people going through mental health difficulties, being connected to and sharing experiences with others who have gone through something similar is hugely important, especially for feeling less alone
 - not having their needs as young people appropriately addressed by services and having to repeat their story over and over again because services don’t communicate with each other, is a big barrier to recovery
- We know we are far from achieving universal access to mental health promotion and support services for our young people, and access is something of a ‘postcode lottery’.¹⁷⁶

What the evidence shows is good practice

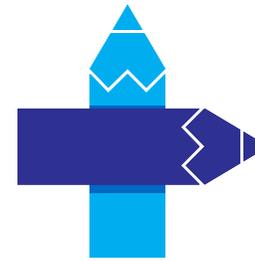
Again, the most important evidence for what works and what doesn't for young peoples' mental health comes from the voices of young people themselves, their families, and others who interact with them.

These voices say that fostering positive teacher-student, school-family, and peer to peer relationships has a positive impact on student wellbeing.¹⁷⁷ Programs which focus on promoting good mental health rather than on reducing existing 'problem' behaviour are more effective.¹⁷⁸

Teachers themselves often feel overwhelmed by the demands placed on them, and adding mental health to the mix can feel like a role which they are inadequately prepared or resourced to fulfil.¹⁷⁹ Sometimes they feel so overstretched that they need mental health support themselves, not able to give to children what they do not have.

“The areas that need to be addressed are so numerous it is overwhelming. Each student's needs are unique even within situations such as abuse, separation or poverty.”¹⁸⁰

“Governments ... fail to recognise that their demands are placing undue and unreasonable expectations on schools and school systems ... Governments must stop loading schools with more to do without providing extra, effective resources to be able to do it.”¹⁸¹



In terms of helping young people to negotiate their own transitions successfully, 'a rich and varied school education is probably the best intervention that society can offer'.¹⁸²

Traditional pathways through education do not suit everyone. **Tailored support and flexibly delivered education pathways** may be needed by young people who have disconnected from, or are at risk of dropping out of, 'mainstream' school.¹⁷¹

Such alternatives are ideally part of a whole-system effort to promote engagement in education. Victoria has a goal to foster a 'socially inclusive education system' where schools offer a welcoming and responsive environment to the full diversity of students' needs.¹⁷¹

Each state has a slightly different approach but there are dozens of examples of programs for people with mental health difficulties.¹⁸³ Although these programs lack a strong evidence base because of patchy evaluation, there is some uniformity about good practice principles: delivering learning in environments which do not resemble a school, tailoring one-on-one support, and employing staff who can develop meaningful relationships with young people.¹⁸⁴

Evaluations also show that it is important for **whole-school programs** to go beyond information distribution and be able to be tailored to local circumstances and school populations. Initiatives which focus on tackling specific issues across the school community are more likely to be effective.¹⁷⁸

For families experiencing social or economic disadvantage, help to provide a supportive environment at home and **foster family resilience** is a key part of a preventive intervention in the early years.¹⁸⁵ The 'Triple P' positive parenting program is an example of a well-evaluated intervention which can effectively prevent or manage childhood behaviour difficulties.^{186,187} Programs which are culturally embedded and which involve families and the community are more effective for Indigenous students.¹⁷⁸



Supporting a parent while negotiating your own transitions

What it means for Shannen, Queensland

When Mum became sick I was left alone to pick up the pieces. I had to cut back my work hours and I went from great study grades to fails within weeks. I was struggling to sleep and was always scared that something would happen to my Mum. My boss and workmates helped me when I was not coping and became distressed at work.

I first became involved with a local support service when I was 17 and Mum was admitted to the mental health unit. I met my support worker when I was struggling to care for Mum during day releases.

Being Mum's carer I had to sort out many things on her behalf, like debt collectors and real estate people chasing me. Because I was only 17 they refused to deal with me personally and services would not help me until my support worker became involved.

She assisted with making those demands cease and further guided and supported me with all the stressors in my life. I doubt that I would have been able to deal with these challenges alone without her help.

As Mum's carer, I can't be unwell when she needs me. I had to keep myself safe when I lived alone and experienced my own mental health crisis because caring for Mum was so demanding and scary.

Until I became involved with the support service I had no idea how to understand the effects of Mum's mental illness on me or how to look after myself.

They never turned me away. To be supported when trying to learn how to deal with Mum made things seem a bit easier.



 Watch Shannen's video at www.mentalhealthcommission.gov.au

Spotlight issue

Transitions beyond school



Leaving school and entering further education, training, or employment also means leaving behind familiar structures and supports.

This transition may be especially difficult for young people who are also living with mental health difficulties. They are at greater risk of not being in education, employment or training.¹⁸⁸ This may have lifelong implications for health, unemployment, under-employment and poverty.¹⁸⁹⁻¹⁹¹ Australia ranks amongst the worst OECD countries for the rate of employment of people with a disability, including mental health difficulties.^{192,193}

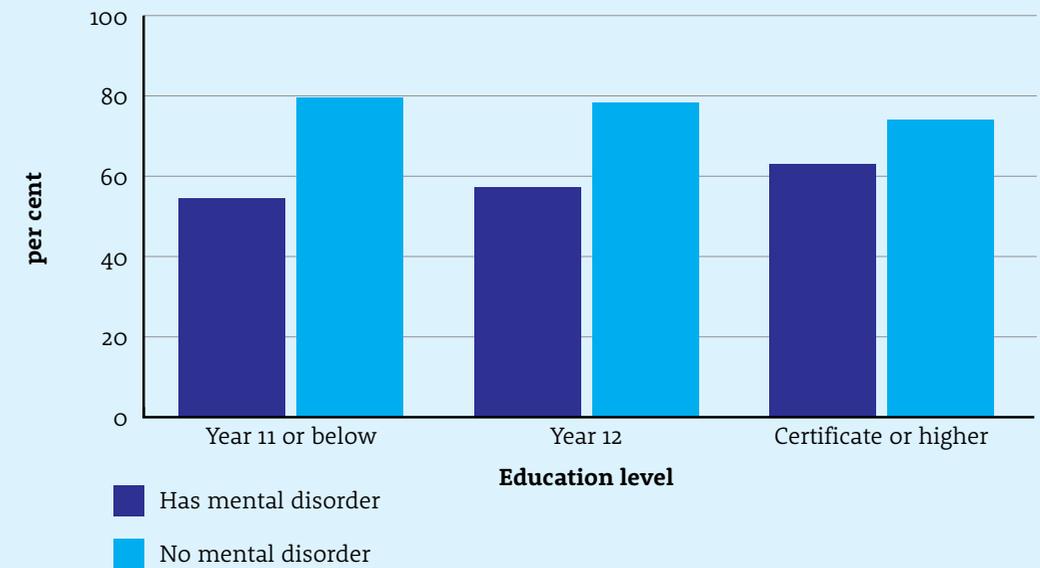
So what will turn this situation around? The Commission believes in strengths-based approaches, built on the idea that helping people to live contributing lives does not mean changing them, but rather changing the system and environment to support this goal.¹⁹⁴

Post-secondary education providers and employers can remove barriers to attaining and continuing employment. This could include being flexible to the episodic nature of many mental illnesses and to the side-effects of medications.

Higher expectations among professionals of what a person can achieve, and eliminating discriminatory attitudes, will allow people to achieve their potential according to their strengths.¹⁹⁵

Funding and service structures can create disincentives to employment through loss of benefits or due to the lack of advocates to help people navigate what is available to them.¹⁹⁶

Figure 10: People aged 15-24 years who are fully engaged in employment and/or education by highest level of education and mental health status



Source: ABS National Survey of Mental Health and Wellbeing 2007

Specialised **supported education** enables adults living with severe mental illnesses to receive individual tutoring or counselling and other mental health supports while attending mainstream college or university. There is some evidence that this has positive effects on wellbeing, self-esteem and quality of life, and results in improved educational and employment outcomes.¹⁹⁷

For those making the transition to work, the **individual placement and support (IPS)** approach involves training people with mental health problems on the job and helps people to gain competitive employment.¹⁹⁸ IPS does not exclude anyone who wants to work, supports peoples' preferences, continues support once employment is gained, and integrates support provided with that of the person's mental health team.¹⁹⁹

The Commission understands that TAFE plays an important role in providing a pathway to re-engagement in education for those with a mental health difficulty. It is imperative that increasing investment in school-based education does not result in cutbacks to Vocational Education and Training provision.

Using online technologies to reach out to young people

What it means for Sarah, New South Wales

The capacity of a young person to effectively manage transition periods throughout their life has a great impact on mental health outcomes as an adult.

ReachOut.com leverages the latest technologies to provide young people who are going through periods of transition, with evidence-based help and support 24 hours a day. Issues young people face include physiological changes and developmental responsibilities such as forming relationships and emotional independence, as well as the challenges of moving from primary to high school.

Our online mental health service focuses on helping young people aged 14 to 25. This period of time can be very difficult for many, and can lead to high stress levels, anxiety, fear and insecurity.

As Senior Manager, Schools for the past two years, I know that school is also an important time for teachers to play a vital role in supporting people with mental health problems, through education.

ReachOut.com Professionals, provides teachers with the very latest evidence-based information so they can better understand mental health and wellbeing. Teachers are shown how to refer young people who are experiencing mental health difficulties to appropriate services, how to access practical online tools and are supported to do so through accessible online professional development.

As an example, the Leadership Team of one of the schools we work with has implemented our resources as part of their school wellbeing program because of the support it provides to both students and teachers. It has provided great opportunities for discussions between students and teachers and enabled the students to feel comfortable talking about how they feel and access help.

I'm proud that ReachOut.com helps young people tackle everything from finding motivation to getting through really tough times.

 Watch Sarah's video at www.mentalhealthcommission.gov.au



What we don't know

Where we need more evidence and to shine a light

First and foremost, there is a lack of active engagement of young people in the design and implementation of the types of initiatives discussed in this chapter.

On the whole, we have only a limited picture of what is acceptable and appropriate in their eyes. Social media platforms offer unprecedented opportunities to reach young people and gather their views.

The Commission looks forward to the findings of the second national *Child and Adolescent Mental Health Survey*, which is currently underway, to get an up-to-date picture on the extent and type of mental health challenges faced by our young people.

We have no information available in Australia about the extent of school dropout directly attributable to mental health issues, and little research about the best methods for helping young people experiencing mental health difficulties to remain engaged in education.

This is partly because many initiatives are not sustained, and there is a lack of longitudinal evaluation of the impact of the many initiatives in place in schools on childrens' mental health and longer-term outcomes. We welcome efforts to track childrens' wellbeing over time, such as the *'Growing up in Australia'* study and the ongoing *Longitudinal Survey of Australian Youth*.²⁰⁰

A common theme which does emerge from existing evaluations of school-based emotional wellbeing programs is the challenge of involving parents and families.²⁰¹ Some disadvantaged groups are often seen by services as 'hard to reach'. But it could be that services are 'hard to access'. Access difficulties could be due to services seeming irrelevant, judgemental, or culturally inappropriate.²⁰² More needs to be done to investigate effective ways that schools can work in partnership with parents and families to support childrens' mental health.

There are significant gaps in research regarding the best approach to targeted interventions for children and young people who are known to be at higher risk of developing mental health difficulties – such as Aboriginal and Torres Strait Islander children, those who are geographically isolated, young carers, and international students.

When it comes to transitions to employment, there is little evidence about how to effectively support young people (as opposed to adults re-entering work) who are experiencing mental illness whilst starting work, particularly those who have mild or moderate problems.

Those who have left the formal education system with few or no qualifications tend to fall off the research radar. Without knowing about these peoples' experiences of education or their reasons for leaving, we cannot begin to understand how to tailor flexible education for people who need extra support to stay engaged due to the impacts of their mental health difficulty. Part of the problem is the fear of disclosure of mental health problems which speaks to the need to improve mental health literacy programs in educational settings.²⁰³

Where the Commission is looking for continuous improvement

We call for children and young people, their families and educators to be included in finding solutions. This must include measuring the effectiveness of any supports for young people in terms which are meaningful to them.

For young people, meaningful outcomes can be things like returning to school or work. 'Getting back on the bike' and being held steady for a while is a good analogy for an effective service to support young people going through mental health difficulties.²⁰⁴

Mentally healthy education needs to be embedded within learning of any kind – in schools, colleges, universities and vocational training environments. There is insufficient coherent, integrated support for teachers and educators to enable this. Police forces are providing mental health training to support their frontline officers to better identify and respond to people in distress. Teachers and educators could also benefit from a similar approach. This should be accompanied by increased recognition and support for the mental health needs of educators themselves.

The Commission acknowledges that friends are the first line of helpers for young people who are struggling.¹⁷⁵ Friends are cited time and again as the source of help young people are most likely to turn to if experiencing difficulties with their mental health. Friends want to help others who are going through a tough time, but often do not know what to look out for or what to say. They also need to be given the practical help and support in these circumstances.

Young people tell us that the most appropriate and effective tool for them to learn about supporting their friends is peer

education – hearing frank accounts from people of a similar age about their experiences with mental health difficulties.

With significant school education reform now underway, the Commission strongly urges the integration of mentally healthy education approaches into its implementation. The reform is significant, not only for the amount of money being invested, but also because of its socially progressive emphasis on targeting more intensive intervention at those who are disadvantaged or marginalised.

NEW DATA

"Kids need to be educated at school, when they are young, so that when problems arise they can talk about them openly instead of keeping them to themselves. I didn't know what to look for. Signs that I took for being adolescence were signs of his depression. For years he suffered on his own."¹¹

Inter-generational cycles of disadvantage can only be broken if people who are marginalised can be re-engaged at whatever age or stage of life they may be.

This means that flexible options for engagement – not just sticking to traditional education pathways – must be universally and consistently available throughout Australia.

Investing in sufficient, appropriate services which are acceptable and accessible to young people is assured of a good return. A person who has been helped to negotiate life's transitions from an early age and has a strong educational foundation can fulfil their potential, realise their aspirations, and contribute to their community and family for the rest of their lives.



Feeling safe, stable and secure:

The justice system and mental health

Grant, New South Wales

My first admission to a psychiatric ward was at fourteen. Mental illness constantly stalked me from a young age. What was originally diagnosed as ADHD was actually very early onset schizophrenia. School was a struggle due to my unstable emotional outbursts, paranoia and crippling depression. Making friends was almost impossible and I spent a lot of time on my own.

My illness deteriorated rapidly when I started smoking pot. One thing led to another and at 18 I ended up in a maximum security.

I went from being a Forensic Patient to a medium-security unit in a hospital. After a major setback, Clozapine stabilised me and I was a new, fully-functional person. My progress suddenly went into overdrive.

I was transferred to a minimum security cottage and for the first time in a decade, I didn't have half a dozen locked doors between me and the rest of the world.

I dreamt of going to TAFE and I wasted no time in signing up for a Certificate III in Information Technology. I was fulfilling a dream that was impossible just six months before that point.

My attendance was borderline perfect; I worked hard and graduated.

Rather than feeling stupid like I did at school, it was clear that I could achieve whatever I wanted to as long as my illness wasn't in charge.

I began work which helped me secure a permanent position. I've been there nearly a year and it's going great. Writing for a living is more than I could have ever hoped for.

2013 was a new year, and a new life. I've gone from wearing tracksuit pants in a community workshop to a collared shirt in head office.

I encourage you to fulfil your potential. Don't let your illness rob you of the future you want.



Watch Grant's video at www.mentalhealthcommission.gov.au

Introduction

The Commission is highly concerned about how we as a society criminalise people who live with a mental health difficulty.

We know that people living with mental illness are over-represented in our prisons, in the number of police incidents and in the number of police shootings.^{205, 206}

We were dismayed to learn that in 2012,

38%

of all people entering our prison system reported having been told they have a mental illness.⁷⁰ If these findings were applied to the 29,000 prisoners in Australia,²⁰⁷ then this would equate to **around 11,000 people each year.**

We are highly concerned about what opportunities there were for them to get the right support and treatment when they needed it. This could have helped them avert a life in prison, a loss of their liberties and human rights, and therefore avoid the punitive and mental health-eroding environment of prison. It would have stopped the subsequent double discrimination from having a criminal history as well having a mental illness, when trying to re-establish a life in the community.

The case for alternative pathways is clear. The current pathway costs governments up to \$1 million each year for each person with a mental health disorder or cognitive impairment who come into frequent contact with the justice system.²⁰⁸

The case for early intervention – for young people and families – is also clear. Compared to other prison entrants, those with poor mental health have more extensive and early imprisonment histories, poorer school attainment, higher unemployment rates and higher rates of substance use.⁴⁶

This is a cycle of vulnerability that crosses generations. Twenty-one per cent of all prisoners reported that they had a parent imprisoned while they were a child, 22 per cent had themselves been in juvenile justice detention and 73 per cent had been in prison before.⁷⁰

This is a tragic cycle and one that has to stop.

This chapter will shine a light on the opportunities to provide interventions to improve mental health and reduce offending. It will focus on ways to create alternatives to imprisonment for those with mental health difficulties, to reduce offending behaviour whilst simultaneously protecting their human rights.

We will also shine a light on the particular concerns we have about the mental health of Aboriginal and Torres Strait Islander prisoners, and of those who are detained under forensic orders.

What do we mean when using the term ‘forensic’?

The term ‘forensic’ means connections with or to the court or justice system in relation to a mental health condition or matter.

As such, the discussion on forensic mental health services includes court assessment and liaison services, hospitals, community services and follow-up, juvenile justice services, police and prisons.

People with a mental illness who come into contact with a court or the criminal justice system can be either diverted from the criminal justice system into treatment, or may be found not guilty by reason of mental illness or unfit to plead due to their mental illness.

Diversion programs are usually run by courts that consider minor offences and how the person’s mental health can be supported to reduce the chance of re-offending. This involves the court arranging a mental health assessment of the person, development of a treatment plan and diversion into community-based treatment which is then regularly monitored by the court.

People who are considered by a court as not guilty or unfit to plead due to their mental illness are sent for treatment in a mental health facility – such as a forensic hospital. Forensic hospitals are generally operated by health services, not the corrections or prison system. Upon discharge into the community, the forensic service can continue to monitor and provide treatment and follow-up services for the person. People within this broad group are *forensic patients*.²⁰⁸

There are also many people with a mental illness who are sentenced or on remand whose mental illness worsens during custody. Like others who may develop a physical health problem, they are transferred to a hospital or mental health facility for treatment, and upon improvement are transferred back. People within this group are *correctional patients*.²⁰⁹

Appropriate outpatient-type services in the prison setting can also be provided by a forensic health service to provide ongoing treatment for a mental illness, just as there would be if the person had diabetes or chronic heart failure.

What we know

In 2012 almost two in five people when entering prison reported they had a history of mental illness.⁴⁶

This is shocking. It is almost **double** the 12-month prevalence of mental illness in the general population.⁴⁹

We know that these elevated levels of mental health difficulties are consistently seen across studies in Australian prisons and correctional facilities. This relates to high levels of psychological distress and mental health disorders.

It is a national problem.

We know that prisoners with a mental health difficulty present with some of the most complex health needs.

Thirty-two per cent of overall prison entrants reported having chronic health conditions and a mental illness⁴⁶, or a mental illness as well as a specific impairment. For example, one study has found that 66 per cent of prisoners with a cognitive impairment also had a mental health and or a substance use disorder.²¹⁰

These are people with complex health and social challenges.

We know that people with a mental illness who find themselves before a court or in prison have had a journey that may have involved previous court appearances as a juvenile, little involvement in treatment programs for their

mental illness and a high chance of a co-existing alcohol or other drug problem. We know that for new prisoners mental health nurses, psychiatrists, psychologists and social workers are the most accessed health professionals.⁴⁶

Sadly we know that opportunities are repeatedly missed for turning lives around – **in a 2012 survey 33 per cent of prisoners who had been told they had a mental health condition had been in prison five or more times, compared to 26 per cent of prisoners who had no condition.**⁴⁶

Re-establishing a life after prison is even more challenging when a person is also experiencing high levels of mental illness.

People in the community who have been in prison report twice the prevalence of any 12-month mental disorder compared to people with no history of imprisonment. Compared to the general population, they have:

Almost five times

the likelihood of experiencing a substance use disorder in the previous 12 months (22.8 per cent compared with 4.7 per cent);

Three times

the likelihood of experiencing an affective disorder such as depression or bipolar disorder in the previous 12 months (19.3 per cent compared with 5.9 per cent); and

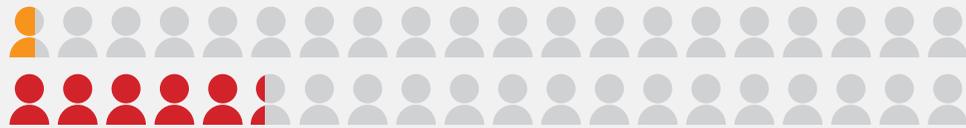
Double

the likelihood of an anxiety disorder in the previous 12 months (27.5 per cent compared with 14.1 per cent).⁴⁹

We know that support for family members is often lacking and they are often at a loss about what they can do if their relative becomes involved with the criminal justice system. As a family or support person, the arrest of someone you care for can be shocking, frightening and stressful, and throw you or the whole family into crisis. In addition, children struggle with adjusting to having their family member in the criminal justice system, especially when it is a parent.

Families often do not know what to expect or how to navigate the criminal justice system, especially if the person they care for experiences mental illness. There is worry and fear for the person who is in the criminal justice system and uncertainty about what will happen next.

Mental health and wellbeing impacts of prison for Aboriginal and Torres Strait Islander peoples



Aboriginal and Torres Strait Islander peoples are over-represented in Australian prisons. While they comprise only **three per cent of Australia's population** at 30 June 2012, they made up **27 per cent of the adult prison population**.^{207, 211}

This is shocking.

Of this group, nine per cent were female, with an increase of 20 per cent in the female Aboriginal and Torres Strait Islander prisoner population since 30 June 2011.²⁰⁷ Further, Aboriginal and Torres Strait Islander young people aged ten to 17 years were 24 times more likely to be in detention than non-Indigenous people that age, 15 times more likely to be under supervision, and 15 times more likely to be under community-based supervision in 2010-2011.²¹²

Incarceration has serious mental health impacts for Aboriginal people;²¹³ and in turn, mental health conditions are associated with high incarceration rates.

A 2009 survey of NSW prisoners reported that 55 per cent of Aboriginal men and 63 per cent of women reported an association between drug use and their offence.²¹⁴ In the same sample group, 44.5 per cent of men and 51.9 per cent of women had previously been assessed or treated by a doctor or psychiatrist for an emotional or mental health problem.

In a more recent Queensland study, at least one mental health condition was detected in 73 per cent of male and 86 per cent of female Aboriginal and Torres Strait Islander prisoners; with 12.1 per cent of males and 32.3 per cent of females diagnosed with post-traumatic stress disorder.²¹⁵

What the evidence shows is good practice

While our states and territories have adopted different practices, worryingly little is known about how these align with best practice approaches.



Furthermore, the evidence of good practice is underdeveloped. We do not fully understand how access to treatment and ongoing support can reduce relapse into ongoing crime or improve mental health in the long term.

Despite the massive burden of mental illness borne by this population and their heavy use of public services, there is a paucity of research to identify good practice, what interventions are most effective and what works best for different groups of people who come into contact with the justice system. Some specific studies and some services have been positive.²¹⁶

The only evidence we do have is from isolated examples of promising practice. Some of these are models that focus on diverting people into earlier treatment and support, or funding into early intervention approaches.

Listening to people with lived experience

Promising practice must incorporate the views and stated needs of the people who will be affected by it. This is no different in the justice system, and we are encouraged that the voices of people with a mental illness in the justice system are being heard and documented in reports such as *Not for Service Experiences of Injustice and Despair in Mental Health Care in Australia*⁸¹ and *Mad in Australia: The state's assault on the mentally ill*.²¹⁷

It is also positive to see that the recent prison health surveys incorporate self-reporting by prisoners about their own health.

Mental health courts and diversion schemes

Diversion approaches are based upon the principle of 'therapeutic jurisprudence' – that people with a mental illness who offend do so because of their illness, and appropriate responses are to provide health treatment, not criminal penalties. They have been operating in Australia since the early 1990s.

Evaluations of mental health court liaison services in both Victoria and New South Wales have been found to be promising.^{218, 219}

Court diversion programs, designed to divert people into mental health care rather than into custody, are also in place. Individual evaluations of the Tasmanian mental health court diversion program and the New South Wales court liaison service have shown them to have reduced the incidence of offending.^{220, 221}

Australia has a history of court diversion since the 1990s when the Magistrate's Court Diversion Program was established in South Australia in 1991 and was followed by the Hobart Mental Health Diversion List in 2007. Victoria and Queensland also have variations of these schemes.

As a principle, people who commit a crime because of their mental illness should be given the opportunity to be diverted into either mental health treatment services in the community, or into the forensic system to receive appropriate mental health treatment and support. The evidence would show that it is effective to do so.

Supporting frontline workers

Police are involved more and more frequently as first responders in crisis situations involving people with mental health difficulties. In New South Wales for example, there was a 25 per cent increase in the annual number of police incidents involving people with a mental health problem between 2008-2009 and 2011-2012. This period saw the number grow from about 22,000 incidents in 2007-2008 to around 30,000 in 2011-2012.²⁰⁵

Tragically for the person, their family and the officers involved, across Australia over the 11 years 1989-1990 to 2010-2011, 42 per cent of people shot by police had a mental illness.²⁰⁶ Police do not join the force to shoot people or to be de facto mental health workers.

There are some promising approaches being taken by police to train their officers and to improve their integration with mental health professionals. The Commission visited the ACT Police this year and saw one such program in operation.

Use of skills training of police forces, such as through Mental Health First Aid, and the establishment of specialist crisis intervention teams (CIT) have indicated reduced arrest rates, reduced use of force and cost savings.²¹⁶

Training of other frontline workers in the justice system who come into frequent contact with people who experience mental health difficulties, such as corrections or court staff, should also draw upon evidence-based approaches.

Restorative justice

Good practice can also include restorative justice approaches which focus upon the whole-of-person needs of the offender as well as the victim. This can help minimise the negative impacts upon mental health, support community re-integration and reduce re-offending.²²²

Supporting people

People in the criminal justice system need to be provided with information about how their families can help them, and families too need to know how they can receive help. The development of guides or handbooks for families, such as that in New South Wales, is a positive step to provide families and support people with knowledge of what to expect and the ways of the justice system.²²³

Justice reinvestment – turning lives around

In Australia Dr Tom Calma AO, Adjunct Associate Professor for National Centre for Indigenous Studies at the Australian National University and a former Aboriginal and Torres Strait Islander Social Justice Commissioner, was one of the first proponents of 'justice reinvestment', introducing the concept in the Social Justice Report 2009.²²⁴

Although in his report justice reinvestment is discussed primarily in relation to Aboriginal and Torres Strait Islander communities, the principle has application to many vulnerable groups, including juvenile offenders, and people with co-existing cognitive impairment and mental health conditions.

Justice reinvestment is a criminal justice policy approach that diverts a portion of the funds for imprisonment to local communities where there is a high concentration of offenders. The money that would have been spent on imprisonment is reinvested into services that address the underlying causes of crime in these communities.

Investing in mental health services for Aboriginal and Torres Strait Islander peoples is one avenue to explore through justice reinvestment programs. Based on the available evidence, the Commission is concerned that the high number of Aboriginal and Torres Strait Islander peoples with mental health conditions in prison might be a flow-on result of their lower access to mental health services than other Australians when outside of prison.^{5,70} There is substantial room for improving access to services which may have positive impacts on rates of imprisonment.

This is also a promising approach in economic terms. A recent cost-benefit analysis by the National Indigenous Drug and Alcohol Council has shown that the long-term savings for diversion to community-based rehabilitation for those with substance use problems, compared to prison are as high as \$111,458 per offender. This sort of modelling supports the justice reinvestment argument that imprisonment simply does not make good economic sense.²²⁵

Working together on the front line

What it means for Glenn, Australian Capital Territory

ACT Policing (ACTP) respond to around 300 incidents a month which directly or indirectly have some sort of mental health element.

As a result of this we started the Mental Health Community Policing Initiative (MHCPI), to build effective partnerships and enhance the care and treatment of individuals experiencing mental illness or dysfunction. One of the key elements of the initiative was embedding mental health clinicians in ACTP Operations.

The clinicians receive on average seven queries a shift. At times we deal directly with a mental health consumer or we provide advice and decision-making support to police dealing with mental health consumers in the community. Since inception, more than 3,000 cases have been referred to the clinicians.

Another major element of the MHCPI is the four-day enhanced mental health training program (based on the NSW Police Force MHIT Training Package). The training program is designed around giving members the ability to communicate more effectively with people affected by poor mental health.

The training also provides members with a decision-making framework ensuring better outcomes for mental health consumers. It incorporates sessions on identifying suicide risk factors and through scenario-based training, developing the most appropriate police response in keeping with the principles of least restrictive care.

Since the inception of the clinicians and the training program, the number of police initiated emergency apprehensions has been reduced. When we have serious concerns around self-harm or the risk of harm to others, this legislative power enables police to take a mental health consumer into protective custody and transport them to a designated mental health facility.

Prior to the MHCPI being introduced, emergency apprehensions were enacted on average 70 to 80 times a month. Since the introduction of the MHCPI it has been reduced to around 40 to 50 apprehensions a month.



 Watch Glenn's video at www.mentalhealthcommission.gov.au

What we don't know

Where we need more evidence and to shine a light

We need a nationally consistent picture to see more clearly the experience of people living with a mental health difficulty in the criminal justice system, and how service and supports are provided, and innovative and evidence-based practices are taken up.

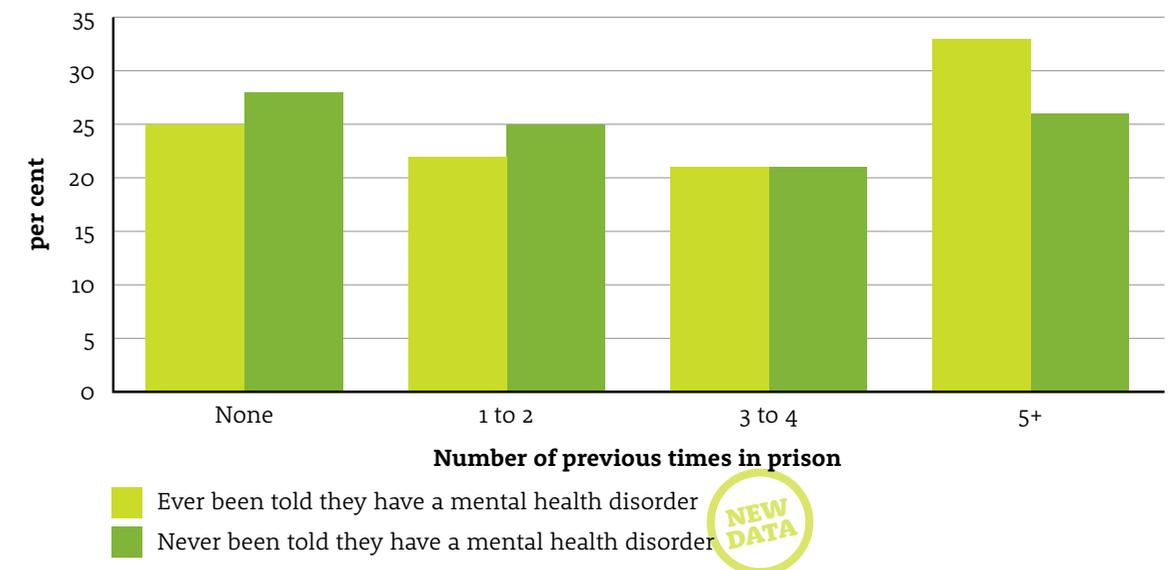
We do not have a national reporting system or consistent framework across the criminal justice, police and court system in Australia.

It is therefore not surprising that being able to see a national picture is difficult. It has only been since 2009 that a regular prison health survey has been undertaken.

We do not have an understanding of the most effective mix of services, and here we especially need more evidence and evaluation. Aside from the promising results of justice reinvestment modelling, we know little of the cost-effectiveness of current or potential services in terms of either health or crime outcomes.

We want to better understand what opportunities there are to intervene early or to support a person living with a mental health difficulty in prison or to divert them from becoming a 'repeat offender'.

Figure 11: Mental health history of prison entrants by the number of times previously in adult prison

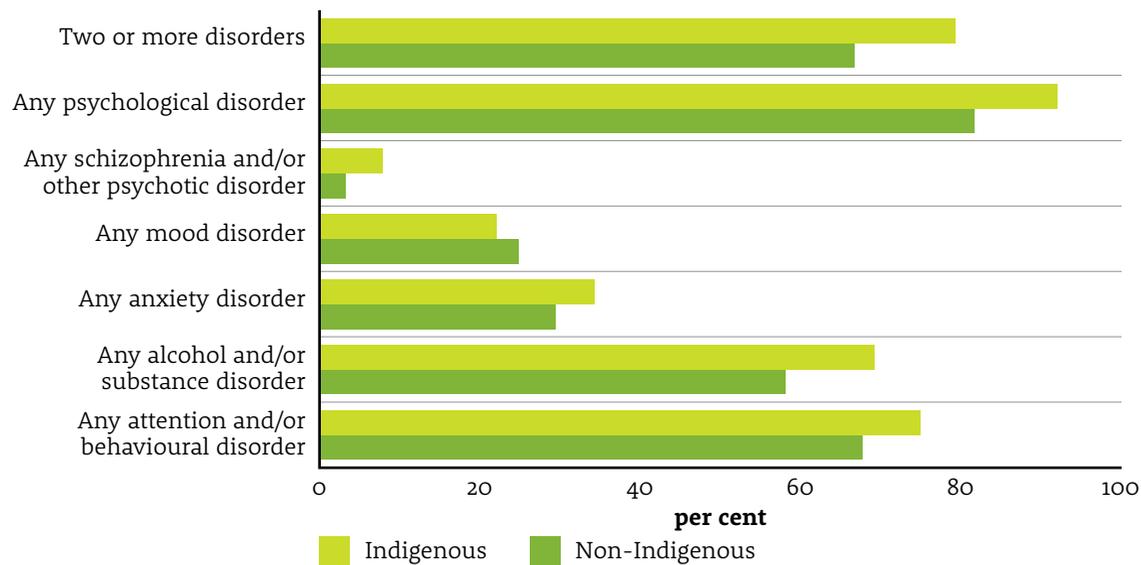


Source: AIHW. Analysis of 2012 Prison Health Census Survey (Unpublished)

The Commission believes there is an urgent need to shine a light on the following:

- Equity of rights and access to services across the different jurisdictional systems. There is also little-to-no evaluation or comparative assessment to see what systems or programs work best in early assessment, provision of treatment and provision of support during detention and after release.
- We need a clearer picture of the whole-of-life benefits for the person in terms of their mental health outcomes and success in other aspects of their lives such as getting secure housing, income and meaningful work. Evaluations of diversion or early intervention approaches need to move beyond reduction in recidivism or offending rates to encompass these aspects as well.
- We need a clearer view of the extent to which promising practice exists, and is able to be scaled-up across Australia; we need piloting and evaluation of diversion and restorative justice approaches; investment in evidence-based programs and court or prison alternatives.²²⁶

Figure 12: People in juvenile detention in NSW with a mental illness



Source: 2009 NSW Young People in Custody Health Survey

Supporting young people

We need to know more about how to support young people to prevent a lifetime connected to the criminal justice system. Mental health problems have been described as being ‘the most prominent of needs of young people in contact with the juvenile justice system.’²²⁷ In New South Wales the *Young People in Custody Health Survey* confirmed the extent of mental health problems, and

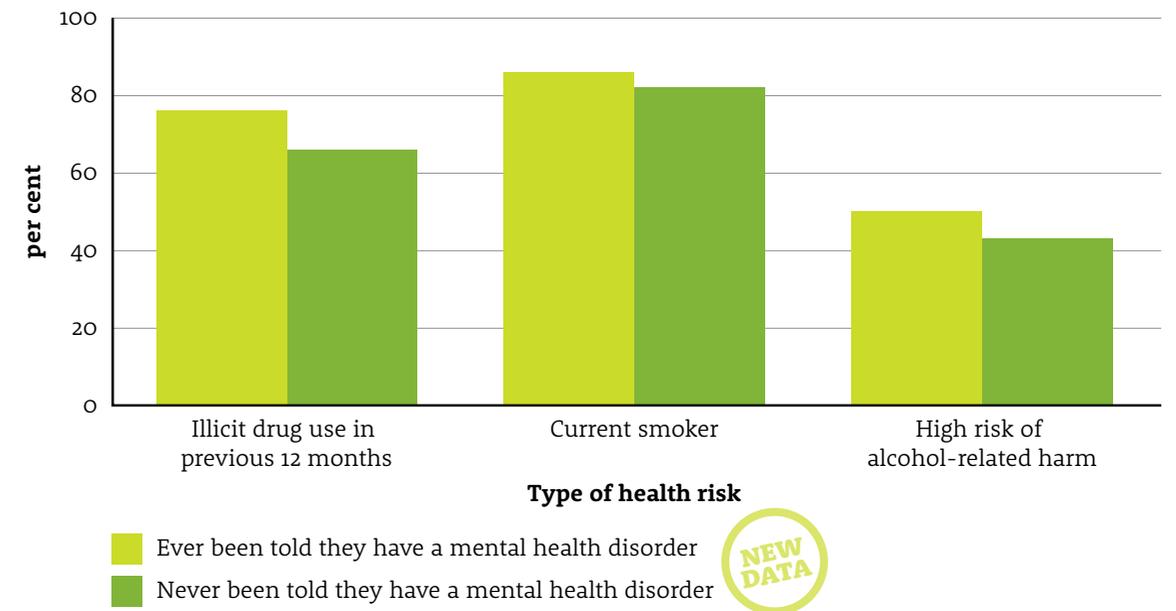
highlighted the higher rates experienced by Aboriginal and Torres Strait Islander youth.

On average, young people in custody had 3.3 different psychological disorders.

Such a shocking figure requires a genuine and urgent response.

We need to both more clearly see and understand what can be done for these young people and what will be effective.

Figure 13: Mental health history of prison entrants by drug use, smoking status, and risk of alcohol-related harm



Source: AIHW. Analysis of 2012 Prison Health Census Survey (Unpublished)

Support after contact with the criminal justice system

The capacity for people who have been in prison to take up the opportunities for a contributing life is reliant upon having their mental health assessed and a mental health plan implemented while they are in prison. It is known that the first two weeks after release

pose the highest risk of suicide, relapse into drug abuse, overdose or re-offending.²²⁸ We need to know what services are best practice and the extent to which these are adopted and implemented to avert these risks. Equally, we need to know what barriers need to be broken to get good practice in place on the ground.

In focus: What it means to be under a forensic order

The care of those under forensic orders is an area about which the Commission is highly concerned. It affects the human rights of individuals, as well as their access to appropriate and equitable treatment in forensic systems across Australia.

In every state and territory people with a mental illness are held in prison or specialist forensic hospitals. These people have either been charged and found not fit to plead due to their mental illness, or they have been found to be mentally unwell at the time when the crime took place. Under these circumstances, their cases are considered under special forensic provisions in each state's legislation – where they are referred to detention in a forensic or secure health facility for health treatment, or released with conditions compliance.

Across Australia in 2010-2011 there were a total of 576 forensic beds, and states and territories spent \$229 million on providing forensic facility and community-based services.^{15, 229} New South Wales had the largest forensic mental health system, with 267 (or nearly half) of all forensic beds, although on a population basis these numbers were on par with South Australia (2.3 beds per 100,000 in NSW compared to 2.4 beds per 100,000 in SA).

We know that people living under a forensic order are in forensic facilities as well as other institutions and in the community. For example, in NSW at 30 June 2007 there were 309 people under such orders – 86 living in the community, 51 in correctional centres, 98 in Long Bay jail prison hospital and 74 in community hospitals. Of these 309, by far the majority, at 208, were 'not guilty' by reason of their mental illness.²³⁰

We know little across our forensic systems about improved health outcomes – though some research has documented the economic benefits of early intervention²⁰⁸ and the potential for service benchmarking.²³¹

Individual commentary or analysis of legislative provisions between jurisdictions illustrate that the rights of people to treatment in the least restrictive environment, or to recovery supportive environments, are not universally assured.^{230, 232, 233}

Reconviction rates among this group are reassuringly low.^{234, 235}

From a national perspective, the key issues impacting people under forensic orders include delayed access to care in health facilities, inadequate 'step-down' and rehabilitative pathways, and differing legal frameworks across the states.

Firstly, the distribution of resources across high, medium, low secure and community environments is not always informed by evidence and this significantly impacts the capacity of Forensic Mental Health (FMH) Services to admit and transition people through these care settings. This means they are unable to progress to *lesser restrictive care* contexts appropriate to their clinical and crime-related needs, and, in turn, delays access to the type of care that is most conducive to their recovery. Such delays are particularly highlighted in cases of prolonged detention in custodial and high secure environments.

Secondly, in most state FMH Services, poorly co-ordinated biopsychosocial rehabilitation models lead to inconsistent recovery plans for patients. Unlike people in the general mental health system, those under a forensic order require

interventions that target the symptoms of mental impairment, as well as offending behaviour. When these clinical and crime-related needs are inadequately addressed, peoples' recovery and community safety can be compromised.

Reflecting the pattern across mental health and justice research more generally, there is little evidence to support the use of many interventions with people under forensic orders, which reduces the rate at which FMH Services adopt such interventions. The inability of FMH Services to provide appropriate interventions may also contribute to delays in addressing *risk*, and in turn, suspend progress from high secure to community care. This highlights a need for increased research within the FMH sector to improve the quality of rehabilitation offered to forensic patients.

Finally, the different legal frameworks across the states influence the way FMH Services are delivered. Such differences have led to varied service models and fragmented understanding about the responsibilities of FMH services. Consequently, outcomes in relation to a) reducing re-offending by those experiencing mental illness, and, b) shifting attitudes about those under forensic orders – are inconsistent across the states. Additionally, the legislative differences do not readily facilitate cross-border agreements straining continuity of care when or if people travel between states.

Spotlight issue

Genuine justice and human rights



We all share common human rights and entitlements to treatment under law and access to appropriate health and supports. When we become ill, come before a court or are imprisoned, we should not lose our human rights.

But in practice, people living with a mental illness do lose their rights.

Our justice institutions need to consider whether this is a dereliction of their duty of care. This duty extends to people who are unwell and may have complex mental health and drug or alcohol problems, to young people with emerging mental illness, and to people whose lives are confined to public institutions.

‘Equivalence of care’ is an essential guiding principle here. This means that people in the justice system should have access to health care, support, and treatment at the same levels as people in the broader community.

The lack of genuine justice

We can see evidence of the lack of genuine justice – justice which respects human rights for those with mental health problems who are in contact with the justice system.

People with mental illness are more likely to be victims of crime. They can be actively discriminated against, with their cases not progressed or their evidence not respected.²³⁶

One UK study found that 16 per cent of people with an established psychotic illness reported being violently victimised,²³⁷ and another study revealed that 45 per cent of people with ‘severe mental illness’ had been a victim of crime in the

past year.²³⁸ Other research showed that one-third of people who had been discharged from inpatient units and who were living in hostels had been the victims of crime in the preceding year.²⁰⁷

Genuine justice is not seen in the disparity between the legal and justice systems across our individual jurisdictions. Equality of treatment is not ensured; differences in treatment can occur at all points in the criminal justice systems.²³⁶ The treatment and rights of people living with mental health difficulties and the handling of their cases can be inconsistent, and have profound effects on their present and future wellbeing.

Our human rights obligations

The Commission considers that genuine justice is about how human rights of people with a mental illness are respected and provided for when they interact with the justice system. Australia is a signatory to both the *Universal Declaration on Human Rights* and the *United Nations Convention on the Rights of Persons with Disabilities*.

On the evidence presented in this chapter, we are failing on one of the obligations from the *Universal Declaration* to “... *the right to a standard of living adequate for the health and well-being of himself... and medical care and necessary social services ...*”²³⁹

The Disability Convention further states that when people with a disability are involved with the justice system they have a range of entitlements. These are to health and health care, legal representation and equality of treatment before the law, and consideration given to the support necessary to ensure their mental health and health needs when their liberty is taken away.

It also states that in order for these rights to be protected, training should be made available to “for those working in the field of administration of justice, including police and prison staff.”

These requirements under the *Convention* need to be taken seriously.

Service and supports, attitudes and practices need to improve, and Australia needs to step up and be genuine about its commitments to its own citizens.

When a family member is in the criminal justice system

What it means for Margaret, Western Australia

Over the past decade, I've been supporting two family members who experience psychosis and drug and alcohol issues. I've seen first-hand the way the system can let people down and not look after them properly.

During a paranoid, psychotic episode one of my family members believed he'd be safer in prison than in the community. He'd never been to prison before but he committed a crime to get there. In prison, it's all about security, not about health. He didn't get the help he needed and deteriorated further.

I felt there was no voice for people or families in this situation. I started a group and we met on a regular basis. We wanted to stop people with mental ill-health ending up in prison and being forgotten about.

As a family member, I just couldn't understand why the systems were letting so many vulnerable people down. I know that when you have mental ill-health and drug and alcohol or criminal justice issues, the sum of distress is greater than the parts. People in this situation don't have complex needs.

They have the same needs as you or I. It's just that services' responses to them require thoughtfulness and co-ordination. That's where the complexity lies – not with the person!

A pilot mental health court is being trialled in WA to help divert people to treatment and care. I'm very proud that family and consumer advocates helped to make that happen.

I'd like to see a much better understanding of why people end up in the criminal justice system. It's not just about mental illness. It's often about lack of co-ordinated service support, poverty, lack of employment, stigma and discrimination.

People need a safe home, someone to love who loves them, something meaningful to do and enough cash to see them through.



Watch Margaret's video at www.mentalhealthcommission.gov.au



Where the Commission is looking for continuous improvement

It is of the utmost importance to have a criminal justice system that gives justice to people with mental illness. Underlying this principle is the need to have a strong evidence base upon which to plan and deliver services, interventions and supports.

This means:

Providing options and support for young people with emerging mental health difficulties to divert them from the courts and prison system.

It is estimated that the younger the age of first contact with the justice system (between the ages of 10 and 14 years), the greater the chance of coming before a court again, and receiving a prison sentence as an adult offender.²⁴⁰ For young people at risk of developing mental illness and who come into contact with the criminal justice system, support and diversion could change that potential pattern.

“... young offenders pose[s] unique challenges. They engage in risky behaviours, have significant primary health needs and present with a range of mental health issues and complex behavioural and social concerns, including their offending behaviour.”²⁴¹

Providing support to adults in the prison and justice system to ensure protection of their health and legal human rights.

The Commission is pleased that the Australian Human Rights Commission is currently investigating this area. We understand their study-to-date has identified case examples of discrimination in the courts, police and prison systems; where a person's liberty may be taken away, not because of a criminal conviction, but due to their mental health status.²³⁶

The human rights of people with mental illness warrant a fair, consistent and reliable approach in the criminal justice systems across the country. Consistency of legislation and practice in the criminal law would make for a good start.

Each state has a different Mental Health Act with different approaches. The new Mental Health Act of Tasmania which is to take force from 1 January 2014, is of great interest. This Act will change the emphasis from risk to self and others, to assessment of a person's capacity. It will have one treatment order regardless of setting and more regular review points by the tribunal. The person and their family will be involved throughout the process.

Better transition and follow-up arrangements for people with a mental illness in custody, prison and forensic facilities upon release or discharge.

People living with a mental illness who commit a serious offence are subject to legal processes under the forensic and justice systems. The rights of individuals who are unfit to plead due to mental illness need to be balanced against the needs of the community. However, access to mental health treatment, and opportunities for rehabilitation and recovery need to be available. The Commission has heard from services, that successful re-integration needs

a staged approach, and currently options for supporting a person through transition back into the wider community are lacking.

The Commission looks to the forensic and prison services and local mental health teams to work together more strongly to provide support through discharge and transitions, to optimise a person's re-connection with the community and reduce risk of a relapse of poor mental health or offending.

Improvements in awareness of legal rights and justice processes.

Australian states and territories need to develop a comprehensive community education campaign to increase awareness of legal rights, court processes and legal assistance and support by people with a mental health issue and their families and support people. This education should be delivered in mental health, community and education settings, in the criminal justice system, and police service.

This is essential to guarantee that people will be treated within their rights.

This approach is based upon one that was developed from the “Inquiry into access to and interaction with the justice system by people with an Intellectual Disability and their families and carer.”²⁴² It aligns with both the perspective of equivalence of access – that all people, irrespective of their health or disability, should be treated equal to that of others in the community, and with human rights provisions that a person should be made aware of their rights in order for them to be able to make informed choices in exercising them.²³⁹

There is a need to reform and reinvest current resources into interventions that work:

- Support for court diversion of people with mental health difficulties from the criminal justice system into community mental health services and custodial transitional services to support people leaving custody.
- We need initiatives that provide people with mental health difficulties, upon their release from prison, with ongoing care and support in the community that address the things that concern them most in life and support them to be successful in re-establishing their lives – such as accommodation, education and employment opportunities.

Reducing the over-representation of people in prison with mental illness.

It is clear that the prevalence of mental illness is strikingly higher among prisoners than in the general population. Only if we see the improvements we have outlined above will we be able to reduce the over-representation of people with mental health difficulties in prison.

This must be a priority.

Unless it does, ‘Australian society [will be] diminished by the increasing use of prison to address multi-layered social difficulties’.²⁴³

We cannot continue with the present situation, where prisons have become our new mental health institutions.

We need to have all our jurisdictions to adopt more consistent legal provisions so that people with a mental illness are equitably treated throughout our nation; we see the high levels of mental health and co-existing physical health problems among the prison population and the high priority to provide the right physical health and mental health treatment and support they require, and we consider that diversion is essential to supporting the individual to bring justice to people living with mental health difficulties to reduce the consequences of living with a mental illness upon themselves and the wider community.

We recognise that a health-based response is needed for people who commit a crime because of their mental illness and that treatment in a specialist forensic mental health system is important, as are supports for people with a mental illness when they leave a prison or forensic facility and start to re-establish their life in the community.

This is what a just system would look like.

The NSW Consumer Advisory Group’s view of what a justice system should look like:

“When you are exiting prison, you receive transitional support, including access to clinical care, accommodation, education and employment opportunities. You are linked in with services in the community so that, if you choose to, you can access ongoing support suited to your situation. Because there are supports that help you adjust to life in the community, you feel positive and optimistic about being in the community. These supports help stop the ‘revolving door’ effect.”²³³



Preventing suicide:

What works in suicide prevention?

Leanne, New South Wales

I have been living with depression, panic anxiety disorder, PTSD and agoraphobia for many years. I have five adult children and lived with a lot of domestic violence in my two marriages. I live with my 22 year-old son. He gave up his navy career at 18 to become my full-time carer after I attempted suicide and ended up in intensive care. I have tried to take my life numerous times.

I was an only child and my father remarried after Mum passed away when I was aged 12. I experienced lots of domestic violence from my stepmother and we never stayed in one place for too long so it was hard to hold on to friends.

I recently attempted suicide again but my son saw the warning signs and called the police. The ambulance staff were very helpful and stayed until I got a hospital bed.

My psychologist arranged for me to have a support worker which has made such a difference to my life. We have set meaningful goals, including improving the quality of my life, being able to get out into the community a little more and able to ask for help when needed.

I am an Indigenous Australian and have traced my heritage to the Noongar people of Western Australia. I would love to get rid of the stigma of mental illness and suicide because I know what it is like to be called a 'crazy woman' and labelled a 'wacko'.

The courts recommended I participate in an Indigenous Elders meeting for mediation relating to domestic violence issues. I wasn't aware of specific Indigenous services, but it's been an amazing experience, helping me with a lot of my issues.

My children are the first people to be there for me, then my psychologist, GP and my support worker. I've come ahead in leaps and bounds in the last two months and my support person is helping me to see things in a positive light.



Watch Leanne's video at www.mentalhealthcommission.gov.au

Introduction

If suicide was a disease, funds would be scrambled and urgent searches started to find vaccines, causes and cures.

No part of our community is immune; suicide kills more young people than anything else and kills three times more men than women. The suicide rate is highest in those aged over 85.²¹

Suicide takes one and a half times as many Australian lives each year as road accidents.²¹ Road accident deaths have substantially reduced in recent decades, but over the same period there has not been the same level of reduction in suicide rates. We can and must do better than this.

We all know that drink driving increases our risk of dying on the road and discussing who will be the designated driver is often part of a night out. We need the same openness with our other conversations. Talking about difficult emotions – even if we notice someone isn't coping – does not come easily to many of us, and suicide is still often a taboo subject.

Every death by suicide expresses unimaginable anguish, and it happens on average six times every day in Australia.²¹ In 2007 over 65,000 people reported attempting to take their own life.⁴⁷

Most of these attempts do not come out of nowhere. Many of these 65,000 people would not live their life in isolation – they may attend school or work (or fail to turn up), talk with friends or family, visit their GP or Centrelink – or they may simply 'fall off the radar'.

In our 2012 Report Card we called for more timely support for those who may be contemplating suicide, and more rapid and local reporting of suicidal behaviour. We repeat this call, and will

continue to do so as long as there is no visible action and preventable suicides continue to occur.

This year we focus on what can drive down our suicide rate and the number of suicide attempts each year. We highlight where our knowledge is lacking in what works best for the community as a whole, and for groups who are more vulnerable to suicide. We look at the geographic, social and economic inequality of the burden of suicide across our communities and shine a light on the troubling level of suicide attempts.

What we know



We know that each year in Australia, more than 2,200 people die by suicide, and that an overwhelming three quarters of these are men.²¹

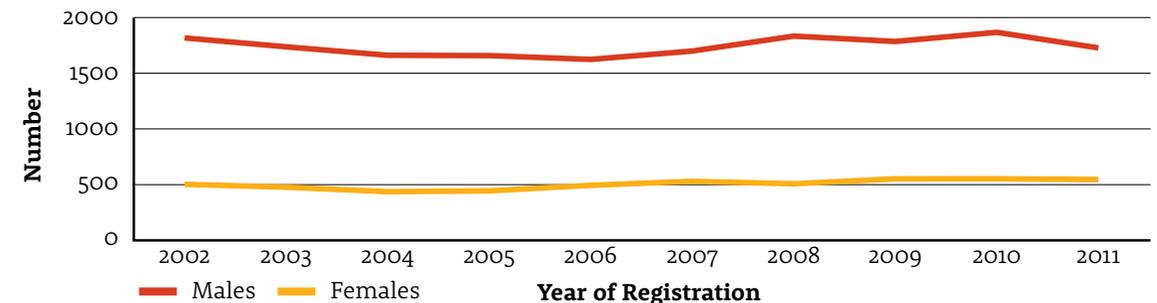
The decade between 2002 and 2011 saw a 15.3 per cent reduction in suicides, mostly due to a substantial reduction in high levels of deaths among young men.²¹ Declines across all groups appear to have stalled in the last few years. Recent changes in data collection methods and review may have contributed to this picture, but it is clear that rates remain too high.

We know that suicide arises from a complex interaction of many vulnerabilities, triggers and factors in a person's life.²⁴⁴ However, suicide is not just an individual act. Social and economic circumstances and differences between cultures also contribute.²⁴⁵

We know this because it hits our disadvantaged and marginalised communities the hardest, reflecting wider social, geographic and economic inequalities as well as everyday discrimination and exclusion.

In our consultations the Commission has been made aware of how suicide affects people in their communities – those at higher risk of suicide include Aboriginal and Torres Strait Islander peoples; those who identify as lesbian, gay, bisexual, transgender or intersex (LGBTI); those experiencing chronic physical pain or illness; some Armed Forces veterans; men who live in rural or remote areas; and people experiencing mental illness.

Figure 14: Number of suicides by sex 2002-2011



Source: ABS Cause of death 2011

Aboriginal and Torres Strait Islander people who die by suicide are half as likely as other Australians to have ever received help for a mental health problem.²⁴⁶ But they are twice as likely as non-Indigenous people to take their own lives.²²

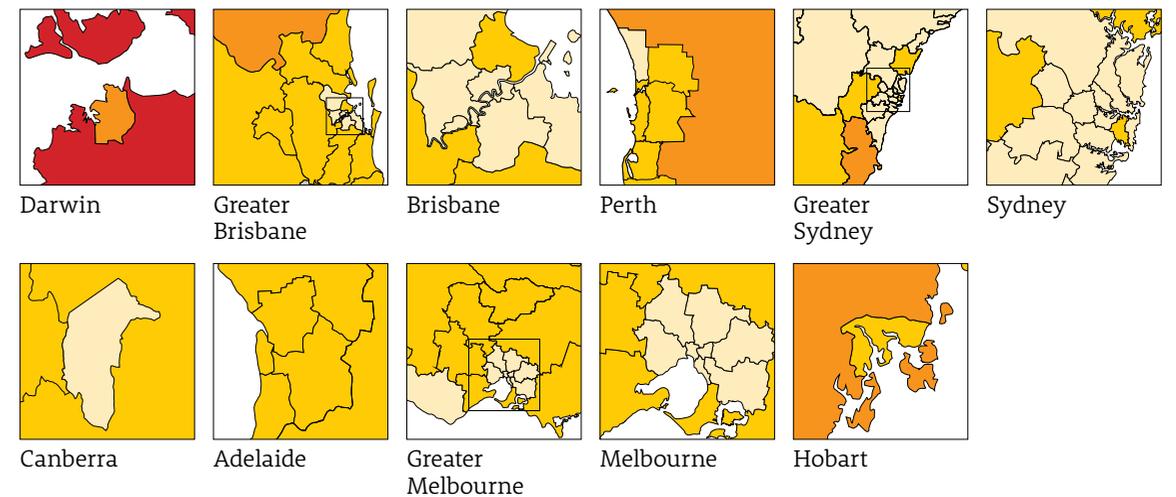
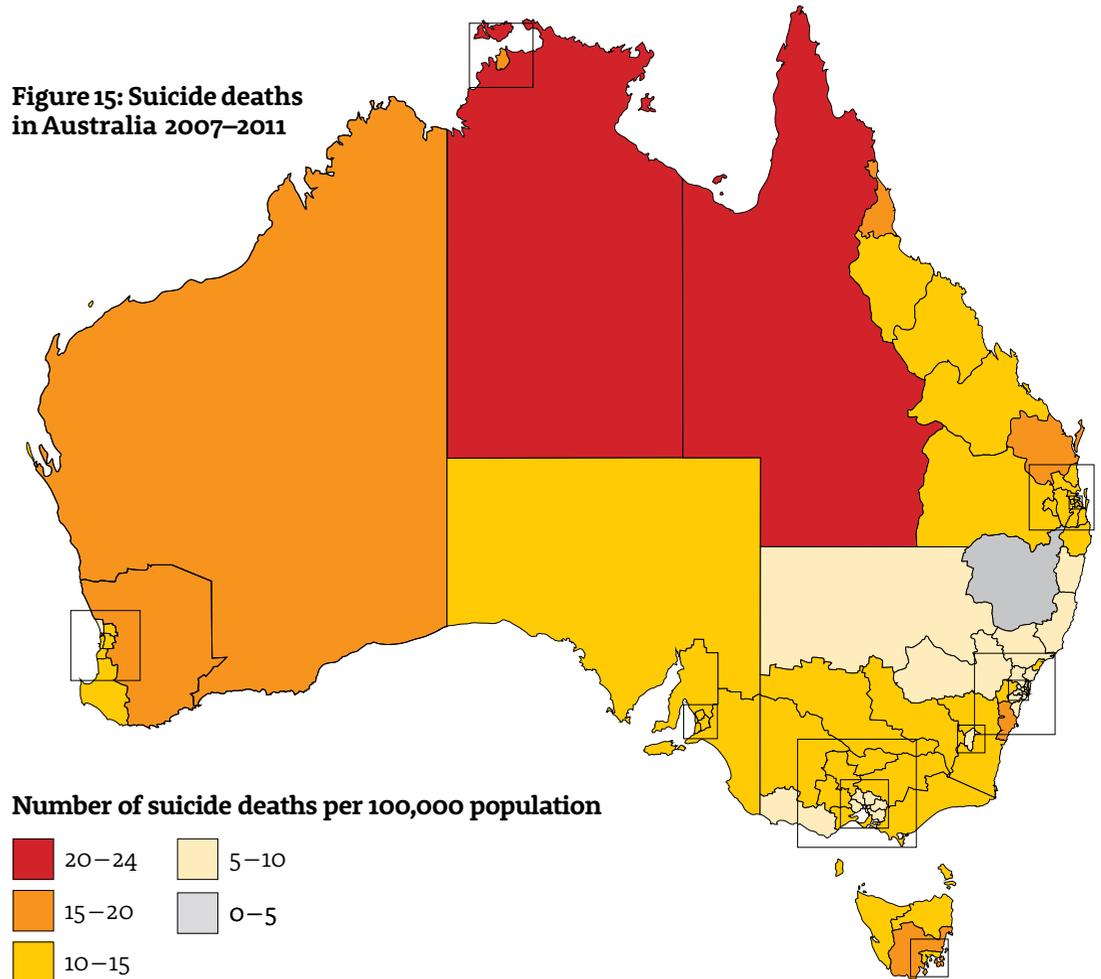
The suicide burden falls disproportionately on **young Aboriginal and Torres Strait Islander men and women** – where those aged between 15 and 19 years die by suicide at 4.4 and 5.9 times the rates of other young Australians respectively.²²

There are stark **geographical inequalities** in suicide rates which this year we show for the first time. Rates are more than twice as high in the Northern Territory (20.0 per 100,000) as in New South Wales and

Victoria (8.5 and 9.5 per 100,000 respectively).²⁴⁷ The map of suicide deaths in Australia at Figure 15 shows this regional variation for the period 2007–2011, with darker colours indicating a higher rate of deaths. People living in non-metropolitan areas are more likely to die by suicide than those living in capital cities,²⁴⁷ and we know that men not living in major cities are almost twice as likely as their urban counterparts to die by suicide.²⁴⁸



Figure 15: Suicide deaths in Australia 2007–2011



Based on ASGS Statistical Area 4. © Commonwealth of Australia 2013

Suicidal thinking, plans and attempts among the LGBTI community are shockingly high. People who identified as lesbian, gay or bisexual reported suicidal thoughts during their lifetime at almost three times the rate of those identifying as straight, and suicidal plans or attempts during their lifetime at four times the rate.⁴⁷



Experiences of discrimination and social exclusion, which contribute to poor self-esteem, isolation, and mental health problems, are behind these high rates.²⁴⁹

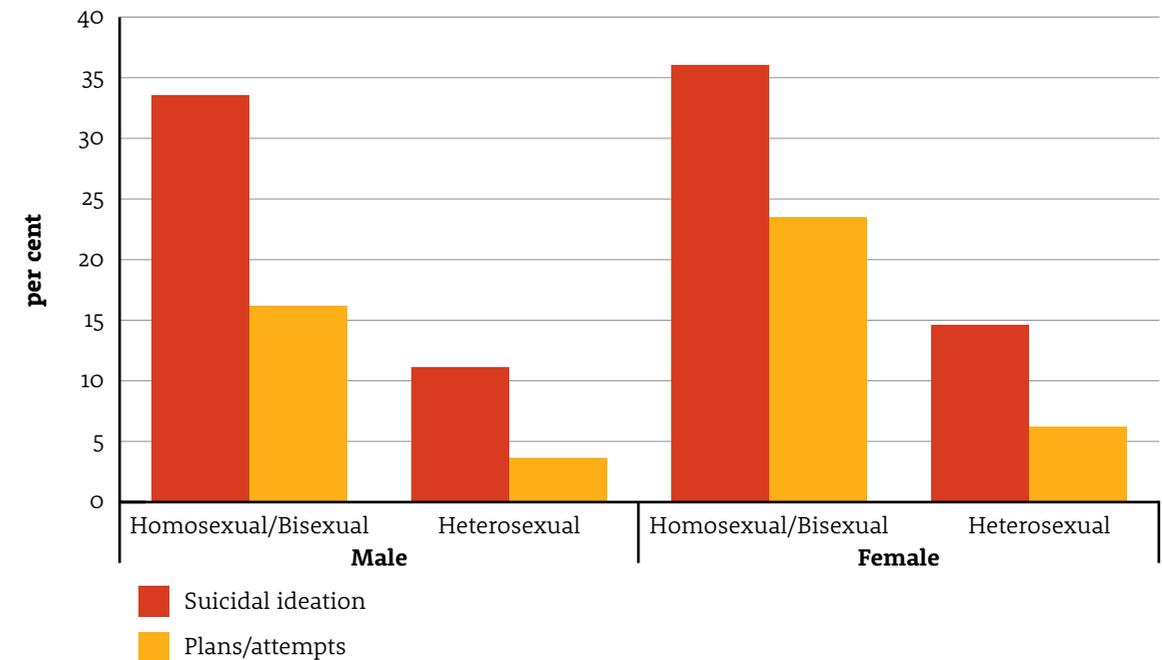
Some life experiences appear to leave some people at increased risk of suicide. For example, although the rate of suicide among serving **Defence Force personnel** is reported as being slightly lower than the general population,²⁵⁰ the risk of suicide is found in some studies to rise over time for Armed Forces veterans. There is international evidence that those who have experienced severe psychological or physical trauma during war have an increased risk of suicide.²⁵¹

Experiencing **chronic pain or illness** are also related to risk for suicide. Recent research in the UK has found that ten per cent of people completing suicide were suffering chronic illness.²⁵² In ‘battling’ the physical illness a person’s emotional wellbeing can be overlooked by family, friends and their treating health professionals; for example, as many as 70 per cent of those diagnosed with cancer think about suicide during the three months after diagnosis.²⁵³

“Due to actual experiences of discrimination and an expectation of discrimination by lesbian, gay, bisexual, transgender and intersex people (LGBTI), suicide and thoughts of suicide are a high risk.”

Susan Ditter , Working It Out Tasmania

Figure 16: Suicidal ideation and behaviours in lifetime by Sex and Sexual orientation



Source: ABS. Analysis of 2007 NSMHWB (Unpublished)

Caring for a returned serviceman

What it means for Melanie, New South Wales

I have been married for 14 years and have two children. My husband was in the RAAF for almost 15 years, and was deployed to Iraq during the Second Gulf War in 2003.

He returned to Australia for a one-week break and I could tell something was not right. After he returned from his second deployment, his whole psyche had changed. He had been debriefed about Post Traumatic Stress Disorder and I encouraged him to see the psychiatrist at the Base Hospital who recognised the symptoms.

One year later, my husband discharged himself; we left the Defence family and had our second child. This was the most difficult time of our lives, with no stable home or income, a newborn baby and a toddler.

My husband continued to deny his PTSD symptoms. I called the VVCS (Veterans and Veterans' Families Counselling Services) Hotline and organised counselling. I learnt to take care of myself and knew that the stress my husband put me under was not right.

I hit emotional burnout 4 years into caring. I had to change. I did a couple of courses through Carers NSW which changed my life. I enforced a short separation from my husband. However, I knew that without me as an effective carer, he was at a greater risk of suicide.

I invited my husband back to the house, after working out some much needed boundaries.

Since then I have learnt to look after myself and express when I need a break.

I went back to study, deliberately relying more on my husband. This was good as it increased his capacity to be a part of the family.

I now work part-time and study one postgraduate subject. I am supported by our community, and also by the Partners of Veterans Association (PVA). They understand what it's like when you need to get away.



Watch Melanie's video at www.mentalhealthcommission.gov.au



What the evidence shows is good practice

There is surprisingly little evidence about what works in suicide prevention.

A message is emerging from recent reviews of research: there is an overall lack of evidence, but there are a handful of effective single interventions to reduce the risk of suicide.^{254, 255} These interventions can be divided into: those aimed at the whole population (universal); those aimed at ‘at-risk groups’ (targeted); and those for people experiencing mental health problems.

We are encouraged that initiatives funded under the *National Suicide Prevention Program* are being evaluated, and this will provide us with much-needed Australian evidence about effective approaches. In the meantime we know that there are several examples of international best practice in this country.

Our literature review of international and Australian research published in the last three years shows that the most effective programs are

those which are comprehensive and systemic and which incorporate multiple but co-ordinated approaches and interventions.²⁵⁶ However, there is as yet little knowledge about how different elements of these systemic approaches interact with each other, how they might be best integrated, nor about how different combinations of approaches work in different settings.

A good suicide prevention approach is not just, or even mainly, about mental health services. Many other agencies and places – Centrelink, homeless shelters, schools and colleges, and workplaces – are far more likely to come into contact with people who are suicidal. In a Queensland study, 63 per cent of those who have survived a suicide attempt report that they have not attended any mental health service or professional.²⁵⁷ Such low contact with mental health services is repeated in other countries.²⁵⁸

Preventing suicide requires action at all levels of government (to plan, prioritise resources, and co-ordinate), services (to identify and target those most at risk), and communities (to drive ‘grassroots’ responses).

The European Alliance against Depression, active in 17 European countries, is one example of a multi-component intervention which has had a positive impact on suicidal behaviour (but less impact on suicide rates). The four main components are: GP education, public relations activity, training of community facilitators and interventions targeted at high-risk groups. Grassroots community networks and community capacity building in suicide prevention deliver this approach.^{259, 260}

Joining up local interventions across agency and service boundaries seems key to effective prevention. The Baerum suicide prevention team in Norway achieves effective community follow up after discharge from hospital after a suicide attempt through a model called ‘chain-of-care’.²⁶¹ Such a model of joined-up support could be extended to alcohol, primary care and other services to encourage them to collaborate in helping those vulnerable to suicide.

For those communities more vulnerable to suicide, targeted interventions are needed. We can see the importance of such a tailored approach which is designed *by and with* – not *for* – community members when we look more closely into what is known about effective approaches for suicide prevention among Aboriginal and Torres Strait Islander peoples.

“Support when my dad suicided and support being a carer would have made a huge difference. I was unwell myself and had to care for my children and my very unwell mum.”¹¹

In focus: Targeted prevention in Aboriginal and Torres Strait Islander communities

The heavy suicide burden carried by Aboriginal and Torres Strait Islander communities is a national shame, and one that impacts across generations.

Australia's first *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* was released in May 2013. It was underpinned by research²⁶² that identified the association between Indigenous communities that have a strong 'cultural continuity' with significantly lower rates of suicide among their young people, in comparison to communities under cultural stress.^{263, 264}

In broad terms, cultural continuity refers to self-determination and cultural maintenance. It is thought that young people from a strong cultural background have a sense of their past and their traditions and are able to draw pride and identity from them. By extension, they also conceive of themselves as having a future as bearers of a continuing stream of culture.²⁶⁵

Participants in the consultations for the *Strategy*, drawn from across Indigenous Australian communities, consistently called for community-focused, holistic and integrated approaches to suicide prevention with an emphasis on investment in 'upstream' prevention efforts to build community, family and individual resilience, and on restoring social and emotional wellbeing.²⁶⁵

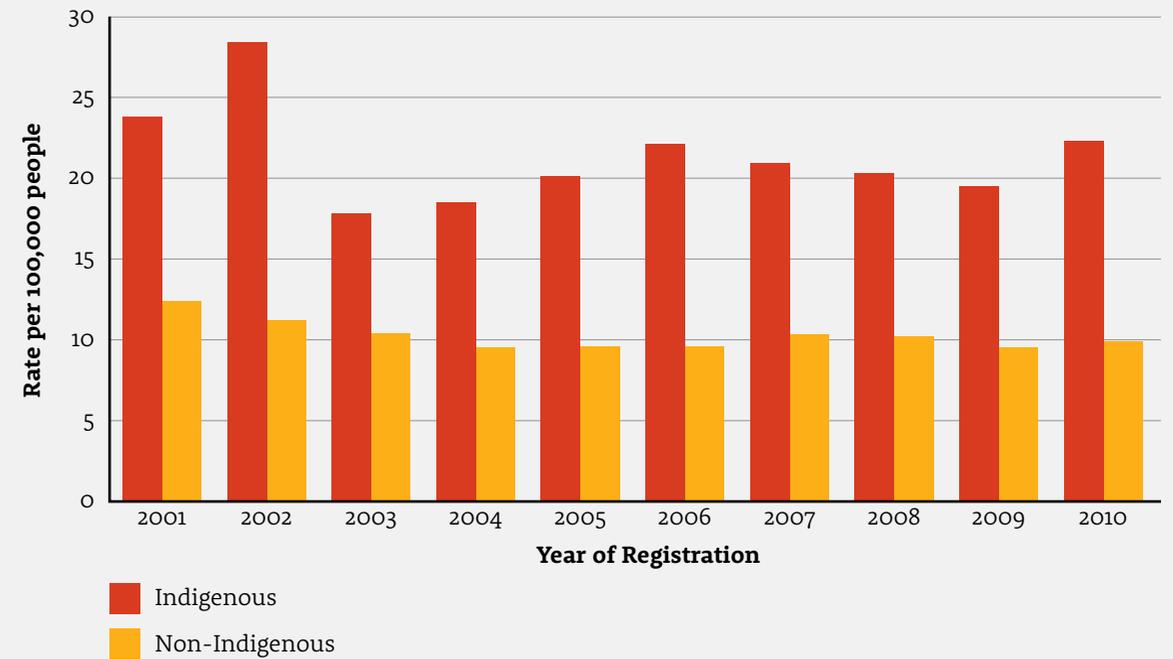
There is a high level of need in Aboriginal and Torres Strait Islander communities for a range of culturally appropriate and locally responsive healing, empowerment and leadership programs and strategies.²⁶⁴ Critical to the success of these responses is a high level of community ownership.

Fostering cultural continuity is a vital part of suicide prevention in Indigenous communities. Decreased suicide rates have been

found to correlate with the number of indicators of cultural continuity present in a community, including: self-government, land claims, community-controlled services, (including police and fire services, health services, child protection and education), knowledge of Indigenous languages, women in positions of leadership, and facilities dedicated to cultural purposes.^{263, 264}

A further critical factor is the presence of culturally competent suicide prevention services in communities. An example of quality indicators for such services can be found in the *Operational Guidelines for Aboriginal and Torres Strait Islander Suicide Prevention Services* to the Access to Allied Psychological Services (ATAPS) program.²⁶⁶ According to these guidelines, services should aim to:

Figure 17: Suicide rate for Indigenous and non-Indigenous populations, NSW, Qld, SA, WA and NT



Source: ABS Suicides Australia, 2010

- provide culturally safe, non-triggering management, treatment and support to Aboriginal and Torres Strait Islander peoples at high risk of suicide or self-harm at a critical point in their lives and to mitigate the reverberations from suicide in the client's community
- be based on Aboriginal and Torres Strait Islander peoples' definitions of health, incorporating spirituality, culture, family, connection to the land and wellbeing and grounded in community engagement.
- establish management protocols that reflect the multiple levels of diversity found in modern Aboriginal and Torres Strait Islander populations, and
- be staffed by administrators and clinicians that are trained and understand mental health and suicide prevention cultural safety

Optimally, such approaches need to be developed and provided in partnership with Aboriginal Community Controlled Health Services.

The Commission remains committed to witnessing a decrease in the rate of suicide in Aboriginal and Torres Strait Islander communities, and will continue to keep this as one of our key areas of interest.

What we don't know

Where we need more evidence and to shine a light

Suicide is often described as being 'in the shadows', 'hidden', or 'silent'. The true prevalence of suicide, how to reliably predict it, and how to best prevent it are also largely hidden from our view.

Suicide research focuses on the epidemiological study of prevalence and risk factors. We are lacking qualitative work with those bereaved by suicide, who experience suicidal thoughts, or who have gone through a suicide attempt.²⁶⁷ Accessing in a sensitive way this lived experience is a research priority, if we are to better understand what helps and what doesn't. It is a priority which may be jeopardised by the preoccupation with risk of many research ethics committees.²⁶⁸

Even basic information about rates of suicide is difficult to know accurately, because of differences in reporting standards, difficulty determining intent, delays in coronial verdicts, and insurance- and stigma-related barriers. Australia is currently attempting to standardise suicide reporting across the country. Without this, we cannot know whether interventions have had any positive effect.

There is no assessment tool or known constellation of risk factors which can reliably predict the likelihood that someone will take their own life.²⁶⁹

In terms of what works for suicide prevention, we are only just starting to scratch the surface. We do not know the impact of our *National Suicide Prevention Strategy*, for example, on suicide rates.

One particular aspect of implementation which we instinctively know would help is continuity of care and follow-up.²⁷⁰ This deficit in our current systems has been emphasised in the highest level inquiries and policies.²⁷¹⁻²⁷³ This work recognises the need for collaboration between government departments, levels of government, local service providers from health, education, justice, housing and employment, and service planners and people at risk.

We are far from having an integrated system of prevention backed up by standards, evaluation and monitoring to provide:

- community-level understanding of warning signs
- clear and easy access points for help, and
- a 'seamless service' for those at risk of suicide or who have attempted suicide.

Part of the problem is that our suicide prevention policies and strategies currently do not offer any sense of what interventions should be prioritised.²⁵⁶ We have a fragmented system made up of isolated programs running in parallel. This approach does not catch people falling through the 'gaps' between services or ensure they access help in the first place.

One solution has been proposed by leading Australian suicide researchers, who recommend widespread implementation of the few proven prevention approaches, alongside small-scale piloting and evaluation of innovative approaches.²⁷⁴

Spotlight issue Suicide attempts



It has been estimated that over 2.1 million Australians have seriously considered suicide in their lifetime and over half a million people have acted on these thoughts.²⁷⁵

Each year, about 65,300 people attempt to take their own life. The patterns of inequality we have seen in suicide rates are also reflected in attempts, with the exception that women are more likely to attempt suicide than men.

The biggest risk factor for a completed suicide is a previous attempt.²⁷⁶ We know from international evidence that for people who sought hospital Emergency Department (ED) treatment following a suicide attempt, one in six attempts is followed by another within the following 12 months, and that up to one in twenty of those people attempting suicide will die by suicide during the next nine years.²⁷⁷

Supporting those who have made a suicide attempt is a significant opportunity for preventing later deaths.

We are hampered in this effort because we are lacking good follow-up data on what happens to people who self-injure or attempt suicide. As a result we cannot know what services and supports actually work. We repeat our call for better community surveillance and communication about suicide attempts.

Any suicide attempt indicates extreme psychological distress. Although we have some statistics about who attempts suicide, we know very little about peoples' actual experiences. We have commissioned the Centre for Research Excellence in Suicide Prevention to undertake a 12-month-long research study into the nature of such experience, focusing on what helped and what didn't help people and their families, before and after an attempt.

We know that projects which seek to provide brief interventions in the Emergency Department accompanied by follow-up and outreach can greatly improve outcomes for this group,²⁷⁸ but also that at present people presenting at EDs can receive poor treatment and little or no follow-up on discharge.²⁷⁹

We know less about how to provide outreach services which can intervene before a person gets to the point of attempting suicide. Continuity of care and post-attempt support is known to significantly decrease the chances of a person later taking their own life. We will aim through our study to ascertain the degree to which services across support sectors play their role in ensuring outreach and continuity.

In the meantime, we are encouraged by action taken by police and ambulance services, especially in Victoria, to record suspected suicides in a standardised way. Near real-time reporting of suspected suicide and suicide attempt data by the ambulance service is currently being trialled, but unfortunately this data was not made available to us. We look forward to learning whether this initiative uncovers new information about the rates and patterns of suicide in our communities.

Preventing suicide in LGBTI communities

What it means for Virginia, Tasmania

As the Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Project Officer for Relationships Australia, Tasmania (RA TAS), my role is to develop and implement the LGBTI Suicide Prevention Community Action Plan.

The LGBTI CAP was developed to guide suicide prevention activities for LGBTI people in Tasmania and is an action under the Tasmanian Suicide Prevention Strategy 2010-2014. It is a fluid document that will be updated regularly as activities are completed and new actions agreed.

State-wide consultations with LGBTI community members formed the development of the LGBTI Community Action Plan and three regionally based working groups were formed.

Through the working group, new partnerships were formed between RA TAS stakeholders and the police, health, justice, children and youth, mental health, non-government organisations, education and local LGBTI organisations.

Six key action areas are highlighted in the LGBTI Community Action Plan including: Challenging discrimination and prejudice; Improving

education and training; Better access to services and information; Improving health services; Improving crisis and emergency response; and Reducing isolation.

This project was met with many challenges and barriers. Some of those included: working state-wide with many organisations and community members; the political arena of the LGBTI organisations; communication breakdowns between organisations; the conservative nature of some organisations and suspicions from others of what exactly we were doing. There are, however, many more organisations that are very supportive.

Change is slowly occurring and there is certainly willingness of those currently involved to make changes in their own organisations and in their sectors. Work has now commenced on implementing the recommendations and actions in the Plan. Over the next 12 months we will be closely monitoring and evaluating our progress to ensure that we can measure what has actually occurred and where there may still be gaps moving forward.



Watch Virginia's video at www.mentalhealthcommission.gov.au

Where the Commission is looking for continuous improvement

The Commission wants to see improvement in four key areas in suicide prevention. These are all related to the need for greater understanding of effective ways to reduce the rate of suicidal behaviour and death from suicide.

First, there must be increased funding for research and implementation efforts in line with the burden of disability, suffering, and potential years of life lost to suicide. A recommendation of the 2010 Senate Inquiry into Suicide in Australia recommended a doubling of national suicide prevention program funding and that future increases on top of this be informed by research.²⁷¹ The Commission agrees that where we spend money must be based on mandatory and continuous assessment of outcomes. This would form the basis of cost-effectiveness estimates and policy prioritisation.

A second priority is the development of published standards for prevention activities and joined-up support for those experiencing suicide attempts or bereaved by suicide. Such quality standards exist, for example, in Ireland, which may provide a model for Australia to follow.²⁸⁰ These should be accompanied by a national monitoring and accountability mechanism, recognising that reducing the suicide rate is the responsibility not just of health services but of whole communities.

Thirdly, we need basic infrastructure development to enable us to better assess – in a timely way – the extent and pattern of the problem, and changes over time. Steps towards this are underway; work has commenced on a Victorian Suicide Register to

collate detailed information on all Coroner-determined and suspected suicide deaths since 2000. This follows the Queensland Suicide Register which was established in 1990 as the first of its kind in the Asia-Pacific region. Establishing suicide registers with consistent data throughout Australia would be of considerable value.

Fourthly, in line with our philosophy of a contributing life, the Commission would like to see exploration of what a whole-system suicide prevention and response framework would look like. How can we get agencies which historically work in silos to work together to bridge the gaps fallen into by those vulnerable to suicide? We know so little about how to encourage collaboration to provide person-centred support.

The Commission believes that it is unacceptable that every year, more than 2,200 people lose their lives to suicide. In addition, the hidden suffering represented by the 65,300 people who report a suicide attempt each year is staggering. While we can be shocked at this data, we must not forget that behind each number is a person who feels locked into a hopeless situation.

We have emphasised that suicide is an important public health problem. Given this, it is surprising that there is so little evidence about what works in preventing it. We acknowledge that there are no simple solutions to such a complex issue. However, work must continue to bring suicide rates down and to bring the same level of consciousness to the issue as has been seen for drink driving.

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Glossary

Aboriginal and Torres Strait Islander

A person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander.

Activity Based Funding

Activity Based Funding (ABF) is a system for funding public hospital services where the health service providers (hospitals) are funded based on the activity they undertake; that is, on the number of patients treated and services provided. Australian Governments agreed to implement ABF under the *National Health and Hospitals Reform Agreement 2012*.

Affective disorder

Affective disorders, or mood disorders, are a set of mental illnesses characterised by dramatic changes or extremes of mood. The main types of affective disorders are depression, bipolar disorder, and anxiety disorder.

Anxiety

A common mental illness, characterised by persistent and excessive worry, and ruminative thinking. Common physical symptoms include a racing heart, hot and cold flushes and a tightening of the chest. A person can feel so distressed it can make it hard for them to cope with and participate in daily life or take pleasure in activities.

Australian Disability Discrimination Act 1992

Legislation passed by the Commonwealth Parliament in Australia in 1992 to protect the rights of people with a disability.

Better Access Program

The shortened name for the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative. Under Better Access, psychiatrists, GPs and psychologists (and appropriately trained social workers and occupational therapists) provide mental health services on a fee-for-service basis subsidised through Medicare. These services offer access to short-term psychological therapies through private providers.

Bipolar Disorder

Bipolar Disorder is an illness that results from an imbalance of chemicals in the brain, which can cause episodic fluctuations of mood from extremes of mania (elevated mood which may be out of character for the person), to the depths of depression (persistent low mood).

Borderline Personality Disorder

People with Borderline Personality Disorder (BPD) frequently experience distressing emotional states, difficulty in relating to other people, and self-harming behaviour. Symptoms can include deep feelings of insecurity, persistent impulsiveness, and confused and contradictory feelings.

Burden of Disease

Burden of Disease is a measure used in the study of the health of a population. It is used to assess and compare the relative impact of different diseases and injuries on groups of people (populations). It quantifies the loss of health due to disease and injury that the person continues to have after treatment, rehabilitation or prevention interventions.

Cardiovascular Disease

Also known as circulatory disease or heart disease. Any disease of the circulatory system, namely the heart (cardio) or blood vessels (vascular). Includes heart attack, angina, stroke and peripheral vascular disease.

Carer

A person who has a support role for someone living with a mental health difficulty. They may be a family member, friend or have another close relationship with the person. Also referred to as a 'support person'.

Chronic disease

A diverse group of diseases, such as heart disease, asthma, diabetes and arthritis, which tend to be long-lasting and persistent in their symptoms or development.

Co-existing

The presence of two separate illnesses at the same time in a person, such as co-existing mental illness and substance use problems. This is the preferred term used by the Commission, rather than dual diagnosis.

Cognitive Impairment

Any characteristic that a person has that acts as a barrier to the cognitive (or thinking) process. Can be used to describe poor mental function, confusion, forgetfulness and other mental impairments.

Comorbidity

The presence of one or more illnesses (or diseases) in a person, in addition to a primary disease or disorder; for example, chronic lung disease and diabetes.

Contributing Life

A fulfilling life where people living with a mental health difficulty can expect the same rights, opportunities and health as the wider community. It is a life enriched with close connections to family and friends, supported by good health, wellbeing and health care.

It means having a safe, stable and secure home and having something to do each day that provides meaning and purpose, whether this is a job, supporting others or volunteering.

Contributing Life Project

A range of activities undertaken by the National Mental Health Commission to pilot the best method through which people can talk regularly with the Commission about their daily lives and what may help or hinder them to live a contributing life.

For this project the methods piloted enabled the collection of qualitative information from:

- The community as a whole
- People with lived experience of mental health problems, and their families and supporters
- People who are marginalised and may have difficulty in having their voices heard through traditional survey means.

Further information can be found at:

<http://www.mentalhealthcommission.gov.au/our-work/national-contributing-life-project.aspx>

Criminal Justice System

The system that involves police, courts of law, juvenile justice, prison and corrections facilities, probation and parole, and deals with criminal matters and people charged with an offence.

Depression

A mood disorder where people experience prolonged feelings of being sad, hopeless, low and inadequate, with a loss of interest or pleasure in activities and often with suicidal thoughts or self-blame. People can experience low self-esteem and apathy or a feeling of emptiness.

Diabetes (Diabetes mellitus)

A condition that occurs when the body cannot use glucose normally. Glucose (a type of sugar) is the main source of energy for the body's cells. The levels of glucose in the blood are controlled by a hormone called insulin, which is made by the pancreas. In diabetes, the pancreas does not make enough insulin (type 1 diabetes) or the body can't respond normally to the insulin that is made (type 2 diabetes). This causes glucose levels in the blood to rise, leading to symptoms such as increased urination, extreme thirst, and unexplained weight loss.

Disability Care Australia

Previously known as NDIS (National Disability Insurance Scheme).

Newly introduced national disability insurance scheme which provides individualised support for eligible people with permanent and significant disability, their families and carers.

Discrimination

Prejudicial action or distinguishing treatment of a person based on their actual or perceived membership in a certain group or category of people. This may take overt (intentional and obvious) or subtle (unintentional or embedded in social structure or process) forms.

Discrimination can also include acts that are unlawful under the Australian Disability Discrimination Act 1992.

Diversion Schemes

Programs which seek to divert people who are facing criminal charges in a court into a rehabilitation, treatment or intervention program that is intended to address underlying problems such as drug or alcohol dependency, mental illness, homelessness or extreme poverty. Diversion programs focus on the causes of a person's offending, rather than punitive action.

Early Intervention

Intervening early in an illness or at an appropriate age to avoid detrimental impacts upon a person's health or development. In the context of mental health it is used to describe a co-ordinated approach to assisting a child, young person or adult through the early assessment and identification of risk factors, allowing the provision of timely treatment for problems to alleviate potential health problems. It is a term widely used in both mental health and childhood development.

Epidemiology

The study of health-related factors and impacts at the whole population level. This includes the study of the distribution and determinants of health and health impacting events (including disease or pollution), and the application of this study to the control of diseases and other population and public health problems.

Equivalence of Care

The principle according to which prison health systems are obliged to provide people in prison with the equivalent quality of care that they would receive in the community for a physical health or mental health problem.

Family and support people/supporters

"Family and support include family members, partners, friends or anyone whose primary relationship with the person concerned is a personal, supportive and caring one." A national framework for recovery-oriented mental health services: Policy and theory (2013)

First responders

Personnel who first intervene or respond to a crisis, such as paramedics, police and fire-fighters.

Forensic order

A legal authority to detain a person in a mental health unit or a high security setting. The court may make a forensic order when a person is mentally unwell and unable to stand trial following an offence, or was mentally unwell at the time of the offence.

Forensic Services

Mental health services that work with people who are mentally unwell and who have been through the criminal justice system. Generally, forensic mental health services comprise forensic inpatient units, juvenile forensic services, community services, and prison, court assessment and liaison services.

Incarceration

Putting a person in jail; or imprisonment.

Justice Reinvestment

A program which diverts a portion of the funds spent on incarceration to communities where there is a high concentration of offenders. The money that would have been spent on custodial services is reinvested into education and services that address the underlying causes of crime.

Juvenile Justice

The corrective system for young offenders; for those aged 10-17 years.

Jurisdiction

The geographical area over which an authority extends. In the Report Card this is used to refer to states, territories and the Commonwealth.

Involuntary treatment

Refers to a person being treated for their illness without their consent, either in hospital or in the community. This may occur when a person is assessed as being in need of urgent mental health treatment due to the severity of their illness, a risk of harm to themselves or another person, or where they are assessed as being unable to make decisions regarding their own care.

Lateral violence

Lateral violence, also known as horizontal violence, is a set of behaviours that are damaging to other people, and include gossiping, jealousy, bullying, shaming, social exclusion, family feuding, organisational conflict and physical violence.

Medicare Locals

Medicare Locals are primary health care organisations established under the Australian Government's National Health Reforms to co-ordinate primary health care delivery and manage local health care needs and service gaps.

Medications

Mental health-related medications typically refers to five selected medications groups as classified under the Anatomical Therapeutic Chemical Classification System (World Health Organization), namely anti-psychotics, anxiolytics, hypnotics and sedatives, anti-depressants, and psycho-stimulants and nootropics.

Mental Illness

Disturbances of mood or thought that can affect behaviour and distress the person or those around them, so the person has difficulties in daily life functioning. They include a range of illness such as the more common anxiety disorders and depression to the less common schizophrenia.

Mental Health Literacy

Knowledge and beliefs about mental illness which can impact problem recognition, mental illness management and prevention.

Mental Health First Aid (MHFA)

Mental Health First Aid (MHFA) is the help provided to a person who is developing a mental health problem, or who is in a mental health crisis, until appropriate professional treatment is received or the crisis resolves.

MHFA skills are taught through courses which teach mental health first-aid strategies in evidence-based training programs.

Mentally Healthy Workplace Alliance

A national collaboration between the National Mental Health Commission, business, government and the mental health sector. The Alliance aims to create mentally healthy workplaces across Australia, in small and large business across all sectors. See <http://workplacementalhealth.com.au/>

Micro-discrimination

Discrimination at the personal level; for example, discriminatory attitudes in the workplace by co-workers. See also Discrimination.

Micro-inequity

How individuals are singled out, treated as 'different' or ignored repeatedly during the everyday interactions of life and is based on discrimination (which is not necessarily intentional). The cumulative impact of such interactions can be significant.

Model of Care

Defines the way health services are delivered. It outlines the group or series of services which are required for the optimum treatment of a person or population group for a specific injury or illness, those required across the stages of treatment and across the stages of care (from acute through to non-acute and rehabilitation) whether that be provided in the community or hospital/facility or by different services.

NEET

Acronym used to describe a young person who is 'not engaged in employment or training'.

The Organization for Economic Co-operation and Development (OECD)

A global organisation with membership from 34 countries which works to promote policies that aim to improve the economic and social well-being of people around the world. Representatives of the 34 OECD member countries meet in specialised committees to advance ideas and review progress in specific policy areas, such as economics, trade, science, employment, education or financial markets.

Obsessive compulsive disorder

A form of anxiety disorder where repeated and unwanted thoughts and impulses disturb and dominate a person. Often involves rituals, such as excessive hand washing, checking and counting, which in turn cause anxiety if such actions are prevented or out of control.

Partners in recovery (PIR)

An Australian Government program which aims to better support people with severe and persistent mental illness with complex needs and their carers and families, by improving collaboration and co-ordination.

Person with lived experience of a mental health difficulty

The Commission prefers to use the term ‘people with a lived experience’ to describe people experiencing mental health difficulties, their families and support people, to ensure that our language in the Report Card is clear, both to people who recognise the term ‘consumer’ and those who do not identify with an established mental health consumer movement.

Personal Helpers and Mentors program (PHaMs)

An Australian Government-funded program which aims to provide increased opportunities for recovery for people whose lives are severely affected by mental illness. The program takes a strengths-based recovery approach and assists people 16 years and over whose ability to manage their daily activities is impacted because of a severe mental illness.

Prevalence

The proportion of people in a population found to have a condition at a certain point in time. It is arrived at by comparing the number of people found with a condition to the number of people studied. Prevalence is usually expressed as a fraction or percentage.

Psychiatric Disability

Psychiatric Disability is the consequence and impact of a mental illness on the affected person’s ability to function and is a term used in the Australian *Disability Discrimination Act 1992*. Psychiatric disability may be intermittent and associated with symptoms of schizophrenia, affective disorders, anxiety disorders, addictive behaviours, personality disorders, stress, psychosis, depression and adjustment disorders.

The Commission, however, prefers the term psychosocial disability to describe the type of disability as it affects the daily functioning of a person and to recognise the broader social disadvantage and effects of mental illness on people.

Psychosis

A mental state where a person experiences seriously distorted thinking, actions and feelings. It involves delusions and hallucinations, and can alienate a person from reality. Psychotic disorders are less common than other forms of mental illness.

Qualitative Research

A research approach which aims to gather an in-depth understanding of human behaviour and experience. It makes use of methods such as focus groups, in-depth interviews and observation.

Recovery

“There is no single definition or description of recovery. Starting with the initial assumption that personal recovery is different for everyone, it is defined within this framework as ‘being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues’”. As defined in: *A national framework for recovery-oriented mental health services: Policy and theory (2013)*.

Recidivism

When people re-offend after already being through the criminal justice system.

Restorative Justice

An approach that focuses on the needs of the victims and the offenders as well as the involved community. Victims take an active role in the process while offenders are encouraged to take responsibility for their actions, by apologising or community service.

Restraint

When somebody’s movements are restricted by the use of straps or belts (physical restraint) or sedation (chemical restraint).

Schizophrenia

A mental illness involving seriously distorted thinking, actions and feelings (psychosis) episodically, which makes functioning in society difficult for people with this condition. For about one per cent of the population, schizophrenia develops in late adolescence or early adulthood, and may be with them for the rest of their lives. Once this condition has been diagnosed, medical treatment is generally effective.

Seclusion

When someone is confined in a specific room from which they cannot freely leave.

Sentinel events

A relatively infrequent, clear-cut event that occurs independently of a patient’s condition; it commonly reflects hospital system and process deficiencies, and results in unnecessary outcomes for the patient.

Sexual Orientation

A combination of emotional, romantic, sexual or affectionate attraction to another person.

Specialist mental health service

Services with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental illness or a disability arising from their illness.

Stigma**See also Discrimination**

A negative opinion or judgement held about certain people by individuals or society. Stigma against people with a mental illness involves inaccurate and hurtful representations of them as violent, comical or incompetent. This can be dehumanising and makes people an object of fear or ridicule.

If these propositions are acted upon, these actions are discriminatory – see also Discrimination.

Stigma can occur in the media in the form of reports that refer to inaccurate stereotypes, sensationalise issues through unwarranted references to mental illness, misuse medical terminology, or use demeaning or hostile language.

Self-stigma is the acceptance of prejudiced perceptions held by others.

Structural discrimination

Term used to describe discrimination at the institutional level; for example, workplace practices. See also Discrimination.

Substance misuse

Term used to describe use of a substance which is illegal or inconsistent with medical guidelines.

Substance use disorder

A disorder of harmful use and/or dependence on either legal or illegal substances, including alcohol, tobacco and prescription drugs.

Suicide

Deliberately ending one’s own life.

Suicide attempt

A non-fatal self-directed injury or behaviour with the intent to cause death. A suicide attempt may or may not result in injury.

Suicidal behaviour

Term used to describe behaviours and thoughts that people have to deliberately harm themselves.

Suicidal ideation

Persistent, intrusive thoughts of wishing to be dead, or deliberate planning or actual attempts to take one’s own life.

Support person

“Family and support include family members, partners, friends or anyone whose primary relationship with the person concerned is a personal, supportive and caring one.”

As defined in: *A national framework for recovery-oriented mental health services: Policy and theory (2013)*.

Twelve month disorder

Having experienced symptoms of a mental or physical disorder in the last twelve months.

Twelve month prevalence

The prevalence of a mental or physical disorder in the population over the last 12 months. See also Prevalence.

Under-employment

An employment situation that is insufficient for the person, or jobs that are inadequate with respect to training or potential economic benefits.

Abbreviations

ABF	Activity Based Funding	NMHC	National Mental Health Commission
ABS	Australian Bureau of Statistics	NHS	National Health Survey
ACT	Australian Capital Territory	NSW	New South Wales
ADHD	Attention Deficit Hyperactivity Disorder	NT	Northern Territory
AIHW	Australian Institute of Health and Welfare	OECD	The Organization for Economic Cooperation and Development
ATAPS	Access to Allied Psychological Services	PBS	Pharmaceutical Benefits Scheme
CALD	Culturally and Linguistically Diverse	PTSD	Post Traumatic Stress Disorder
COAG	Council of Australian Governments	PHaMs	Personal Helpers and Mentors
FTE	Full-time equivalent	PND	Post Natal Depression
GDP	Gross Domestic Product	QLD	Queensland
GP	General Practitioner(s)	SA	South Australia
IPS	Individual placement and support	SIDS	Sudden Infant Death Syndrome
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex	TAS	Tasmania
MBS	Medicare Benefits Scheme	VET	Vocational Education Training
NEET	Not Engaged in Employment or Training	VIC	Victoria
NDIS	National Disability Insurance Scheme	WA	Western Australia
NGO	Non-Government Organisation		

Where our work is taking us

Our second Report Card takes us to the next stage of our work program. Some of these activities deliver on the commitments we made last year; others are included under the new recommendations and findings we've made this year.

Our work program from 2014

Undertaking a national review on behalf of the community and making recommendations for reform to the Australian Government. The new Government has tasked the Commission to undertake a comprehensive review of the current mental health system, and the additional resources we need to do it. This gives us the opportunity to put an independent, evidence-informed case to Government about the reforms necessary to improve peoples' lives. It will be our priority for the coming year.

Starting the first full-scale National Contributing Life Survey. This qualitative, whole-of-life survey will capture the experiences of people with mental health difficulties and their families and supporters: what helps people to experience a good life, what hinders them and what makes a difference. We scoped and piloted this in 2013 and the Commission will now settle on an ongoing methodology to 'hardwire' peoples' experiences into our future reports and advice. The regular ongoing survey will also help to set a baseline of current outcomes and measure changes over time.

Considering COAG's response to our 2012 Report Card when we receive it and continuing to push for governments and others to take up our 2012 and 2013 recommendations, including adopting national targets and indicators to drive change.

Working with our Mentally Healthy Workplace Alliance partners to advance good workplace practices in businesses large and small. In early 2014 the Alliance will launch a national kit of practical advice and tools for employers. Next year the Alliance will focus on influencing business leaders and decision-makers to realise the benefits of good work and mentally healthy workplaces to their people, their business and the community.

Releasing the National Seclusion and Restraint Project findings which will draw together evidence on the best national and international practice in reducing and eliminating the use of seclusion and restraint and identifying good practice approaches. We will continue to push for transparent national reporting and improvement in this area.

Releasing the findings of a research study into suicide attempts to give insight into who seeks help from where in the lead-up to and following a suicide attempt, what type of help and follow-up they receive, what type of support people find helpful and the kind of experience and attitudes people and families face.

With state mental health commissions, **continuing to push for the growth and development of the peer workforce.** We will hold a national policy forum of experts in 2014 to discuss action in response to Health Workforce Australia's study into the mental health peer workforce. We will continue to support Community Mental Health Australia as they produce national training and development materials for the Certificate IV in Peer Work.

Identifying and developing future leaders with lived experience of mental health issues. In partnership with the Mental Health Council of Australia and with the expert advice of the National Consumer and Carer Forum, our new capacity building project will mentor emerging leaders and give them opportunities to build their skills. We will support the ongoing development of Aboriginal and Torres Strait Islander leaders in mental health, so that they are able to influence change in systems which will benefit us all.

Continuing to work with the Australian Commission on Safety and Quality in Health Care to look at what it takes to get the proper uptake of national mental health service standards and make them mandatory. Our joint project findings on the standards will be released in 2014.

Continuing to provide policy input to the design and implementation of the National Disability Insurance Scheme and Activity Based Funding.

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