SUBMISSION TO THE ROYAL COMMISISON INTO MENTAL HEALTH – FOR THE TERMS OF REFERENCE CONSULTATION FROM HANDS ON HEALTH AUSTRALIA

HoHA Submission – Terms of Reference 2019

JULY 1, 2019

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INTRODUCTION:

1. Executive Summary and Background

The mission and vision of HoHA are:

Vision: Life changing integrative health and wellbeing services and programmes for the disadvantaged to realise their full potential

Mission: To provide quality health and wellbeing services and programmes to people and communities living in disadvantage, homelessness, marginalisation and social exclusion

Values/Goals: Create Values Welcome – we welcome and accept people as they are – it is integral to all we do.

Community – we build community amongst the people who use our service and establish connections with the broader community.

Empowerment – we work with people to enable them to take control of their lives. The dignity of the person means that each of us has the right to pursue our own path in life. We foster self-worth as a means of empowering people.

Stewardship – we value our staff and volunteers and manage our resources effectively. Staff and volunteers are highly valued and critical to the work.

HoHA also recognises its responsibility to effectively manage the resources entrusted to it by government, philanthropic organisations and donors.

We value principles of integrative healthcare service, sharing, compassion, respect and empathy.

To bridge the gap in the community between government funded healthcare and non-government funded therapies practice.

Hands on Health – Community Clinic Model ©

The Hands-on Health Clinic model provides a range of low-cost health and wellbeing therapies and activities to improve the health and wellbeing outcomes of people experiencing high disadvantage in the local community. It is a much valued and highly used service and led the way across Australia over the last two decades to inform the development of a Hands-on Health model nationally. Research undertaken over the last 12 months regarding the HoHA Clinic Model has shown that:

Program Description: people have improved health and wellbeing.

Impact: this ultimately results in more people having access to therapies and health interventions that would ordinarily be unaffordable and therefore get more out of life. The clinics are part of a ripple effect in the community, helping those experiencing pain (at all levels including mental health) and disconnection to return to meaningful relationships, family life, work and employment,

Individual Value: the relationship is the strongest indicator of value. – Highlighted was – personalisations, genuine care, a safe and comfortable environment, and trust as central to the value they assigned to the services.

Social Value: In all our case studies, local knowledge means local embeddedness which favours a more integrated approach with partners.

Public Value: Trust and legitimacy were recognised as attributes of public value; a person-centred approach was what impacted on the quality of services. Finally, drivers of efficiency included capacity to deliver more than the targets.

The HoHA CLINICS

Within the clinic settings, we see, help and build relationships with thousands of people every year. Many of the individuals we see have a number of mental health and general health issues.

People come in to receive treatments and many of them develop a repertoire and relationship leading to discussions about personal and family issues that they are facing and dealing with.

The clinics also provide opportunities to develop links and friendships through contact with other people, activities and referrals that can assist with isolation and to build social capital and resilience. For example, persons attending the clinic for their appointment will talk to our volunteers, with other people attending the clinic and may then have a coffee and a chat. It is the heart of HoHA, and it makes people feel 'welcomed, understood and not judged'.

Isolation and loneliness are major concerns for people with mental health issues with a report by SANE. In its Report 1 titled "Mental Illness and social isolation (2005, www.sane.org) highlighting the following:

- People with a mental illness experience social isolation to a much larger degree at 66% of people compared with the general population at 10%, making it harder to cope with symptoms and any effects of psychiatric disability.
- 85% of people with a mental illness find it harder to maintain close relationships due to factors such as stigma and misunderstanding. "The minute someone knows you have a mental illness you are treated differently" commented one respondent.
- Low incomes contribute to social isolation and the ability to participate in social activities.
- 90% of respondents highly valued friendships and social relationships which helped to manage and maintain one's mental health.
- 72% of people with a mental illness "rarely" or "never" used community support services

In another research paper titled "Social isolation in people with mental illness" (Carol Harvey, Lisa Brophy, Oct 2011) highlights findings that a third of Australians with a mental illness live alone and of this cohort, 39% of them have "no best friend". The majority of people desire more connections with 45% of participants felt they needed "Good friends".

In our clinics and the programs we deploy, we provide pathways for people to better integrate and develop relationships, friends and social capital within the local community where the clinic is located.

The HoHA Social Model and framework for our Clinics provides much more for people with a mental illness through initially just getting them out of their homes.

As an example, HOHA has a good working relationship with the St Martins Church Community, at our Clinic based in Collingwood, and some of our patients attend a twice weekly BBQ/dinner which again, is an indirect but critical mechanism to break down isolation and loneliness with people in the local community. It is a gathering where the table is the centre of getting to know each other, friends are made, and the Centre becomes a focal point for their treatment.

Case Studies – HoHA

An example of a case study is a man aged 40 years, who attends the Injecting Room in Richmond and also attends our clinic for osteopathic care, nutritional consultation, tools and strategies. He has been attending our clinic for over 12 months and has just informed us that he has put on 10 kg in weight and is feeling a lot more confident; these are stories we love!

[redacted] is a middle-aged woman, unemployed and in pain, who says, that HoHA is about ‘loving care’ and how important it is. She says, “I can tell when I feel someone’s hands on me whether they express loving concern, or whether the person is just working for the money”, at the HoHA clinic, I feel welcomed, loved and alive! It is a place for me to socialize and feel that I have something to say. People at HoHA care.

HoHA Clinic, Programme: Aboriginal Health in Aboriginal Hands Clinic Just wanted to say how great it is that I've been able to receive treatment through The Hands on Health Clinic. I feel welcome and feel it’s a culturally safe environment and the students are fantastic. I have been attending the clinic now since it first started and have been able to reduce my injuries across my whole body. The impact this clinic has had on my wellbeing over the years just by having access to treatment ever Tuesday, I've saved money, I've learnt to how to prevent further injuries and it has dramatically increased my capacity to keep playing all my sport and attend gym. I've encouraged many women to attend. I feel that Aboriginal woman in particular feel shame if there doing something for themselves or they just put up with aches and pains till its unbearable. A lot of the women playing for Fitzroy Stars have received treatment as soon as the aches now start. We've seen a decrease in injury management. It has helped me build confidence, deal with my issues, and feeling disempowered.

Thank you for all that you do to keep the Clinic running week to week. [redacted]

Other work and research has been undertaken into isolation and loneliness and the development of social capital especially by Professor Robert D Putnam in his seminal work "Bowling Alone" (2000) and the work by Mr David McNulty from Great Britain in developing communities and social capital through his work at the local Government level.

Again, these two references above are relevant to the work of the Royal Commission because they can provide insights into how our society has changed but also how providing opportunities for people to connect, interact and better deal with personal issues, especially mental health ones.

Given this backdrop, please find below the recommendations from HoHA about process and themes that form part of the Terms of Reference.

Recommendations - Process

- Ensure that the Commissioners include a person/s as consumers of the mental health system and persons/communities who live in disadvantage (we should have 2-3 within the different age groups, diversity and Aboriginal)
- Advisory group should be representative of people who have lived with mental illness and people who live with physical illnesses, as this is considerable in size – there is a need to better support these people
- Perspectives from consumers, community organisations should be actively sought to provide input into the Royal Commission. They should reflect the diversity of the Victorian population base
- Evaluation and Participation are key; and the engagement process should include a wide range mix of groups, and especially those who do not have a loud voice; active participation, engagement and outreach should be priority.
    - Working with CALD communities
    - Refugee and asylum seekers

- Different demographic experiences

Recommendations: Themes
We recommend that improving outcomes for people experiencing mental health issues should be the key goal, including groups, people for non-English speaking backgrounds, and Aboriginal; and Torres Strait Islander population.

Aside from the suggested themes, that form part of the Royal Commission, other issues should be examined as well: such as- we have found these issues to be associated with mental illness:

- Social determinants of health – stigma, trauma, abuse, cultural issues, challenging stereotypes
- Poverty, disadvantage, isolation inadequate housing, social and economic factors, employment, family dysfunction and family violence – for individuals and communities
- Diversity – how we respond to this factor: Culturally and linguistically diverse communities
- Aboriginal and Torres Strait Islanders, Refugees and asylum seekers
- LGBTIQ people
- People released from prison and the justice system
- Disabilities – people that have disabilities and their carers
- Persons at different stages of their lifespan – especially 50 plus
- People living with co-morbidities

Integration of services is crucial and is continuity of care; across the whole of the health system including GPs, crisis and acute settings, emergency services, forensic services, and of course, community. Mental Health problems can exacerbate physical illnesses and so substantially increase care costs.

Mental and physical health problems have traditionally been treated separately with services designed around conditions rather than patients. Growing evidence suggests that more integrated approaches, with closer working between the broad spectrum of health can improve outcomes while also reducing costs. (ABS National Mental Health & Wellbeing Survey Report, 2007)

Added to the above would also be the justice system, alcohol and drug services, education, and training, all aspects of health care from physical to spiritual – the full life cycle, family and juvenile health. We should also investigate recovery/restoration and what that means for different people – from physical to psychological rehabilitation, those who need more services.

CONCLUSION:
Charities and organisations like HOHA, through its programs and partners, can play their part in helping and referring people with a mental health illness. Information, training and upskilling of the people undertaking this work would assist in this task as well as support for the extension of these services into disadvantaged and marginalised communities. Improved support for the emotional, behavioural ad mental health aspects of physical illness could play an important role for HoHA as part of their clinics programme. The time is now to explore how we can combine mental and physical health can be supported in a more integrated approach.

If you have any queries or would like any further information regarding this submission or the work HOHA undertakes, please do not hesitate to contact me on the numbers or email below.

For further information on this submission, please contact:

Franca Smarrelli
CEO, Hands on Health Australia - [redacted]

Your contribution- From Hands on Health Australia

Should you wish to make a formal submission, please consider the questions below, noting that you do not have to respond to all of the questions, instead you may choose to respond to only some of them.

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

HoHA advocates for a much closer working relationship across the broad spectrum of health. The HoHA Clinic Model provides a range of low cost and wellbeing therapies/interventions and activities to improve both physical and mental health wellbeing. It is a much valued and highly used service and has led the way across Australia over the last three decades to inform the development of a HoHA model nationally.

Disadvantage, social deprivation, poverty strengthen the association between mental and physical ill health (Mercer and Watt, 2007). Improving care for people with long-term conditions and co-morbid mental health problems requires closer working with social care, public health, community organisations, such as HoHA. We are placed to work at the intersection between individuals" mental, physical and social needs, including the provision of support groups and peer delivered services.

The patients who attend the clinic or drop in for other services, a meal, a place to belong, all say that they feel a sense of security, not judged and comfortable. They feel 'normal' in a normal setting.

Investing more funds to NGO's that work on the ground with people and communities, breaking down the barriers - to allow for services, programmes and staff; for NGOS to be well resourced to make the difference.

Develop partnerships with individuals, groups and decision makers in helping to break down the barriers like politicians; sports people and organisations; media influencers both individual and corporate; doctors and other health professionals and their organisations; educational institutions at all levels; religious organisations and leaders to name a few.

2. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

We need more funding for service provision that is beyond health, NGOs, social services, housing, justice, education have some excellent programmes in place: age specific, general depression and anxiety. However, there is a missing link- integration of physical and mental illness; whilst it is complex; the relationship is likely to be two way. For e.g. there is strong evidence that having a mental health problem, including depression or anxiety disorders, increases the risk for onset coronary artery disease and ischaemic heart disease between 50-100% (Benton et al 2007). Mood depression is a common and serious post stroke. According to epidemiological studies, nearly 30% of stroke patients develop depression, either in the early or in the late stages after stroke. Although depression may affect functional recovery and quality of life after stroke, such condition is often ignored. This does not take into consideration, those who are carers for stroke patients, the depression and anxiety they experience.

On employment - how they can contribute with their expertise to improving outcomes for people and their communities. The running of clinics and groups where people can meet, develop friendships and connections whilst breaking down barriers and seeking advice. Some of these real-life instances are detailed in our submission.

The expansion of these services and programs into areas where there is disadvantage and poverty to better connect with people.

3. What is already working well and what can be done better to prevent suicide?

According to the Productivity Commission Issues Report, 2019, The Social and Economic Benefits of Improving Mental Health, there has been no significant reduction in the death rate from suicide over the last decade despite ongoing efforts to make suicide prevention policies more effective. NH&MRC will release National Suicide Prevention Plan in 2020. Suicide costs a total $1.7 billion annually, (KPMG, 2013) a cost to the whole community, not just the loss of an individual and their future.

More than 3 100 deaths from suicide in 2017, an average of almost 9 deaths per day, and a suicide rate for Indigenous Australians that is much higher than for other Australians (ABS 2018).

Investment is required into providing more services, programmes and funding for NGOs to assist people who self-harm and have lethal mood disorder, more responsible reporting of suicides in the media and social media, including entertainment television companies to use guidelines for portrayals of suicide - reducing the risk of contagion. A big player in all of this is underlined by connectivity - more data and research confirm that having a strong sense of community and belongs helps reduce the risk of suicide.

As detailed in our submission, the development of social capital and connectiveness with others is a mechanism to reduce loneliness and to develop friendships which help to reduce and prevent suicide.

The ability to just talk to someone or to get a referral to a professional is important so the ability to access social situations and interact with other people is important. For example, many of the sports programs with young people provide this connection that reduces the factors leading to suicide and the Hands on Health Clinics are also another avenue for this.

Re-examine the Victoria's 10-year Mental health Plan within the context of the Royal Commission.

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

We need to promote effective actions to reduce risk of mental disorders throughout the life course- at the community level and the state (Victorian) level. This includes environmental, structural, and local interventions - we should be promoting mental health in a positive way and investing to build resilient communities.

Action needs to be universal and state-wide - across the whole of society and proportionate to need in order to level the social gradient in health outcomes.

We need an integrated approach; the development of a multilevel framework for understanding social determinants of mental disorders can be applied to strategies and interventions to reduce mental disorders and promote mental wellbeing. WHO has done much work in this area and in developing the framework.

Loneliness, isolation, lack of connection with others and the lack of a friend makes if hard for people to experience good mental health.

In many instances, there are indirect ways for people to find, access and experience mental health services by connecting with other individuals and groups that refer (both in a direct and indirect way) to the services they need. The HOHA clinics and programs we run directly and in partnership with others is one of these ways and just getting people out of their homes and into the community.

5. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

We need more investment on the ground and at grassroots level - and locally to strengthen the mental health/social welfare services that are required.

We need more mentoring programmes, traineeships, services that are positive, safe, culturally appropriate, investments in community clinics, such as the HoHA clinics that offer integrated services and offer treatments for pain management at the whole life cycle level.

As detailed in our submission under Recommendations: Themes, some of the drivers of mental health are disadvantage, poverty, isolation, inadequate housing, social and economic factors to name a few.

Jobs, training, social connectiveness, support services are some of the mechanisms to address these, but they need to be undertaken in partnerships, with the breaking down of silo's both in the public and private/NGO sector and in a wholistic manner. This integration is crucial to better the lives and outcomes of individuals experiencing mental illness.

6. What are the needs of family members and carers and what can be done better to support them?

It is important to provide an adequate continuum of care between formal and informal care.
While care giving can be beneficial for family members and care givers; there is also the potential for burn out, depression and other mental and physical issues. This is particular high in people from non-English speaking background, where there is reliance of family carers - there is a need to alleviate the burden of family carers in this sector. This is also prevalent within the Aboriginal community. For these community groups, culture, language, emotions, family community, spirituality, ancestors need to be past of the carer profile.

Carers provide invaluable, ongoing unpaid support to people who need it because of their disability, chronic illness, mental ill-health, dementia or frail age. More research is required into this sector to then develop a social policy framework that takes into consideration diversity at all levels.

Around 60% of people with a mental illness do not live alone and the people they live with, be they family members, friends or direct carers do need support. They need programs that are easily accessible where they get a break, are able to re-charge their batteries and continue with their duties and responsibilities.

Some of these breaks can be small like groups or activities they or their charges can have during the day and week to full blown weekends and weeks where the person is either in respite or others are looking in or caring for them. If these opportunities are not given, then problems can arise and develop with the carer.

Respite services must be increased and made available to people on a non-discriminatory and easily accessible way throughout Victoria. A one-stop-shop for formal respite services could be developed where access is easily gained but where services can be given from the centre of Melbourne to the middle suburbs, the outer suburbs, regional cities and small towns and rural areas. This is an area that needs further work and resources to make it as simple as possible for someone in Robinvale, Casterton, Loch Sport or Marlo to have a week or two off as it is for a metropolitan carer. Barriers must be broken to assist people to gain this break and other seamless services like transport must be considered.

Cost is a barrier to respite services and these must be considered. For example, a pensioner couple requires the whole pension payment to pay the rent and to provide food and lodging for their daily survival but if you take half of the pension away to pay for respite, this leaves the couple not able to take up the break and this barrier is real for them whereby they may be granted respite but in reality, not able to access it as they will either not be able to pay the rent or other expenses as they arise.

7. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

We think the current models that are being deployed require updating ensuring that the healthcare and social care network (including family members) are supported. Currently, this area is challenged; there is high worker turnover due to stress, recruitment of skilled workers, insufficient training available, low intake of people that speak other languages, and the issues of providing care in remote and rural areas. (NHMRC 2018b)

This are we think requires much debate, discussion and questioning – about configuration and capability both formal and informal carers. Education and training are required and how do we better support informal carers to carry out their role (other than financially).

8. What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

Provide more services – Mental health is linked with housing problems and homelessness (Costello, Thomson and Jones 2013). In Victoria poverty and homelessness has risen by 11% (ACOSS 2012). These issues are complex are often associated with family violence, drug and alcohol abuse, physical and mental illness.

Improve the ability for people to access groups, activities and services on a non-discriminatory basis to build their self-esteem, social capital and lessen isolation by funding these activities on a stable and ongoing basis.

Expand the free TAFE courses and access to short courses for people with a mental illness. By people being able to have these economic barriers removed to courses and education, they are better able to integrate into society and to access jobs. Fee barriers for people to improve themselves and to expand their opportunities is real and is restricting their life chances.

The expansion of access to specialist job seeking organisation that deals with people with a mental illness that gives support and advice is also necessary where they work with people in the first instance to work through the education options and then to work with them to get a job with support. This can be done with NGO's or other organisations. Fund NGOS to also provide programme for up skilling, feeling empowered and able. These are NGOS that work at the intersection, they are crucial.

9. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

It is important that the Commission integrate mental and physical health care as they stretch beyond the specific mental health sector; and include the social determinants for health and the modelling of a social policy framework.

Furthermore, funding is to be available to community organisations and NGOs that work at the grassroots level, supporting people with long term conditions and co-morbid mental health problems. Services need to be redesigned at this level; this could provide potential savings if the models can be integrated.

We also need to expand the clinics network to ensure they are well resourced and can deliver programmes and services advice, treatments, training and education, upskilling and interventions for a health and wellbeing in whole.

Messaging awareness programmes and education - should be about positive Mental Health messages as this will assist with stigma and discriminations issues.

10. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

Good mental health is integral to human health and wellbeing. A person's mental health and many common mental disorders are shaped by social, economic, and physical environments. Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk. In order to reduce these inequalities and reduce the incidence of mental disorders overall, it is vital that action is taken to improve the conditions of everyday life, beginning before birth and progressing into early childhood, older childhood and adolescence, during family building and working ages, and through to older age.

Action throughout these life stages would provide opportunities for both improving population mental health, and for reducing risk of those mental disorders that are associated with social inequalities. As mental disorders affect physical health these actions would also reduce inequalities in physical health and improve health overall. Taking a life-course perspective recognizes that the influences that operate at each stage of life can affect mental health. Populations are made vulnerable by deep-rooted poverty, social inequality and discrimination.

Risk and protective factors act at several different levels, including the individual, the family, the community, the structural, and the population levels. A social determinants of health approach requires action across multiple sectors and levels. The evidence is convincing that policy making at all levels of governance and across sectors can make a positive difference to mental health outcomes. Empowerment of individuals and communities is at the heart of action on the social determinants. (WHO Report 2017).

11. Is there anything else you would like to share with the Royal Commission?

Our intention is that we are committed to improve the human condition – this is our vision overall – it has no expiration date – HoHA is not handout, it’s about giving you a hand to realise your full potential…..we think this is the role of the Royal Commission in Mental Health Victoria.

Privacy acknowledgement	I understand that the Royal Commission works with the assistance of its advisers and service providers. I agree that personal information about me and provided by me will be handled as described on the Privacy Page. ☒ Yes ☐ No