Priority area 1:
Social inclusion and recovery

Outcome

The community has a better understanding of the importance and role of mental health and wellbeing, and recognises the impact of mental illness. People with mental health problems and mental illness have improved outcomes in relation to housing, employment, income and overall health and are valued and supported by their communities. Service delivery is organised to deliver more coordinated care across health and social domains.

Summary of actions

- Improve community and service understanding and attitudes through a sustained and comprehensive national stigma reduction strategy.

- Coordinate the health, education and employment sectors to expand supported education, employment and vocational programs which are linked to mental health programs.

- Improve coordination between primary care and specialist mental health services in the community to enhance consumer choice and facilitate 'wrap around' service provision.

- Adopt a recovery oriented culture within mental health services, underpinned by appropriate values and service models.

- Develop integrated programs between mental health support services and housing agencies to provide tailored assistance to people with mental illness and mental health problems living in the community.

- Develop integrated approaches between housing, justice, community and aged care sectors to facilitate access to mental health programs for people at risk of homelessness and other forms of disadvantage.

- Lead the development of coordinated actions to implement a renewed Aboriginal and Torres Strait Islander *Social and Emotional Well Being Framework*.

Cross-portfolio implications

To support a collaborative whole of government approach, these actions will require work across areas outside health such as employment, education, justice (including police, courts and correctional services), Indigenous, aged services, community services and housing and the arts.

Indicators for monitoring change

- Participation rates by people with mental illness of working age in employment

- Participation rates by young people aged 16–30 with mental illness in education and employment

- Rates of stigmatising attitudes within the community *

- Percentage of mental health consumers living in stable housing *

- Rates of community participation by people with mental illness *

These indicators require further development

Mental health and wellbeing are important for the whole community, including the broad spectrum of people who experience mental illness. Consumers and their families have highlighted that stigma and discriminatory attitudes to mental illness are still prevalent. They have told us that stable housing and meaningful occupation—key elements of social inclusion—are important aspects of their recovery and self determination.

People should feel a valued part of their community, and be able to exert choice in where and how they live. Some groups are at risk of entrenched social exclusion, including those with chronic and persistent mental illness. Developing pathways that support community participation and that allow movement towards greater independence minimises the risk of social exclusion.

Policy and service development needs to recognise the importance of a holistic and socially inclusive approach to health in promoting mental health and wellbeing, that includes social as well as health domains and supports people to establish community engagement and connectivity. This applies to all members of the community including those from culturally and linguistically diverse backgrounds and new arrivals. A socially inclusive approach is especially important during times of economic downturn. The role of the family in promoting wellbeing and recovery needs to be recognised, as does the importance of community acceptance.

There have been significant developments in these areas, including establishment of a national Social Inclusion Board, the development of the *Homelessness White Paper* and the *COAG National Partnership Agreement on Homelessness*.

Maintaining connections and support can be especially crucial during adverse events or periods of transition such as loss of employment, exposure to domestic violence, exiting from prison, and family breakdown

and disruption. Management of mental illness also needs to be linked to good physical health, with engagement between primary and specialised treatment and care. Likewise, physical illness is often associated with mental distress and illness.

There are many good examples where mental health promotion has supported greater social inclusion. The *Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders* developed in 2008 brings together a number of key findings in the area of promotion and prevention. Elements of this include the importance of population based approaches to redress inequities and discriminatory practices, and joining up policies and practices across sectors. Information regarding mental health, mental health promotion and mental health interventions should be widely available, culturally appropriate and accessible, including to young people.

Despite very effective initiatives directed to promoting mental health and wellbeing (e.g. *VicHealth*), and improving awareness and understanding of mental illness (e.g. *beyondblue*), those with mental illness are still at risk of being discriminated against in areas such as employment and housing, and there are still stigmatising attitudes evident in the media and community. Discriminatory behaviour and stigmatising attitudes also occur within the health sector. The mental health workforce in clinical and community living support services needs to respect and adopt a recovery philosophy in how they provide services. The role of 'step up/step down' services and community support is particularly important in preventing relapse and supporting community based recovery.

Recovery in the context of mental illness is often dependent on good clinical care, but means much more than a lessening or absence of symptoms of illness. Recovery is not synonymous with cure. For many people

who experience mental illness, the problems will recur, or will be persistent. Adopting a recovery approach is relevant across diagnoses and levels of severity. It represents a personal journey toward a new and valued sense of identity, role and purpose together with an understanding and accepting of mental illness with its attendant risks. A recovery philosophy emphasises the importance of hope, empowerment, choice, responsibility and citizenship. It includes working to minimise any residual difficulty while maximising individual potential. This is relevant to all ages, including the elderly, and to all those involved—the individual consumer, their family and carers, and service providers.

Within current service delivery, a recovery focus has mainly been championed by the non-government community support sector and consumer advocacy bodies. This Fourth Plan intends that the attitudes and expectations that underpin a recovery focus are also taken up by clinical staff within the public and private

sectors—both bed based and community based. This will strengthen the partnership and sharing of responsibility between the consumer, their families and carers, and service providers.

National actions

Improve community and service understanding and attitudes through a sustained and comprehensive national stigma reduction strategy.

Addressing community attitudes and behaviours requires sustained and multi-pronged activity. There are examples nationally and internationally of effective education and awareness campaigns—for example the *Like Minds, Like Mine* campaign in New Zealand and the *See Me* campaign in Scotland, as well as the *SANE StigmaWatch* program and *beyondblue* in Australia. Such campaigns directed at the whole community need to be supported by more local activity, including in the workplace, and need to work in partnership with the

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Definitions of recovery

The definition provided in the *National Mental Health Policy 2008* is:

A personal process of changing one's attitudes, values, feelings, goals, skills and/or roles. It involves the development of new meaning and purpose and a satisfying, hopeful and contributing life as the person grows beyond the effects of psychiatric disability. The process of recovery must be supported by individually-identified essential services and resources.

The definition developed by Patricia Deegan, a consumer who contributed greatly in this area, is:

Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again… The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work and love in a community in which one makes a significant contribution.

The definition provided by the New Zealand Mental Health Advocacy Coalition in *Destination Recovery* is:

… a philosophy and approach to services focusing on hope, self determination, active citizenship and a holistic range of services.

media. They need to include those illnesses that are more complex and difficult to understand such as psychosis. They should also work in conjunction with actions addressed to particular groups such as those from culturally and linguistically diverse backgrounds, rural and remote communities and particular age groups.

Legislation and the introduction of rights based charters are also ways to support destigmatisation. Feedback from consumers, families and carers has highlighted that stigmatising behaviour and attitudes are sometimes encountered in mental health services, and that consumers themselves may have stigmatising attitudes. These need to be the focus of targeted programs to address this, including the incorporation of a recovery approach in staff training and development. People affected by mental illness should be supported to take action on discrimination encountered in health, education, employment and community services.

Coordinate the health, education and employment sectors to expand supported education, employment and vocational programs which are linked to mental health programs.

Education and employment success has a significant impact on a person's self confidence and wellbeing. It promotes development of friendship, community engagement and improved quality of life. Unfortunately mental illness and mental health problems are associated with increased risk of unemployment, and associated negative consequences.

There is now a good research base (for example, the work of the Queensland Centre for Mental Health Research) that, for people with mental illness, remaining or returning to employment can be improved through the introduction of vocational support closely linked to treatment service delivery and support in other areas of life. Some models involve clinical services; others have greater

emphasis on non-government support agencies. Some involve post placement support as well as employment readiness support.

Mental health services can provide advocacy and take a leadership role in supporting closer engagement with employment and education sectors. For example, they can promote and facilitate the placement of vocational support officers within clinical and community support services. They can also assist a person to maximise their capacity to engage with the community through fully utilising the skills of a multidisciplinary team including teaching psychological techniques, and enhancing social skills training.

Related to this action, a *National Mental Health and Disability Employment Strategy* has been developed by the Australian Government to address barriers to employment faced by people living with disability, including mental illness.

Improve coordination between primary care and specialist mental health services in the community to enhance consumer choice and facilitate 'wrap around' service provision.

Over the past few years, the range and focus of community based services has increased. Community mental health services now include a range of clinical services provided through primary care and specialist mental health services, such as acute assessment, continuing care, and intensive outreach; and living support services, such as accommodation and support, home based outreach, day program, carer respite and vocational support services delivered through non-government organisations. Some of these are targeted towards aged people in the community, others to adults or families. The importance of good physical health care has also been recognised as has the role of the general practitioner. The private sector also needs to be recognised in the development of greater coordination.

However, community mental health services in a given area are often provided through different locations and different organisations with limited integration between service elements. Development of partnerships and linkages between service types—both through co-location and service agreements—can promote coordination and continuity of care, and enhance consumer choice, as well as ensuring that physical and mental health care are considered jointly rather than separately.

Integrated care centres or greater utilisation of community health centres may be options for the development of services to deliver coordinated care and improve access. The development of partnerships or 'platforms' which deliver a more holistic service response may require new governance models to oversee and drive change in service delivery. There will also need to be consideration of funding models and how these can be adapted to promote more flexible and person centred responses. Determination of effectiveness could be supported by the adoption of a national tool to measure performance against recovery based competencies.

Adopt a recovery oriented culture within mental health services, underpinned by appropriate values and service models.

Elements of this approach include targeted workforce development, establishment of an effective peer support workforce, and expansion of opportunities for meaningful involvement of consumers and carers.

From the perspective of people with emotional, physical, sensory or intellectual differences, they overwhelmingly report their experience as being one of social exclusion. The link between disability and social exclusion is well documented. Meaningful and diverse means of addressing structural barriers that exist for people excluded because of emotional and psychosocial experiences need to be developed to begin to expand

opportunities for enhanced participation of consumers and carers.

Consumer and carer leaders need to actively promote, lobby and encourage an approach that introduces and acknowledges best practice in policy and activity. This approach should promote the individual's value and strengths, encourage participation and relevant and equitable service provision. Best practice models that promote the development of a certified peer specialist workforce accountable to peers and to funders are elements of a recovery oriented framework of service provision.

Develop integrated programs between mental health support services and housing agencies to provide tailored assistance to people with mental illness and mental health problems living in the community.

Provision of a sufficient number and range of accommodation options with varying levels of support was an important recommendation from recent inquiries. Options may range from single person independent housing through to shared and intensively supported accommodation. Support may include clinical assessment and treatment, or living skills and vocational support. This depends on collaboration between agencies and engagement of local communities. In particular it requires close cooperation between the providers of public housing and tenancy management, and mental health support services to tailor support to that required by the consumer.

People need different types of support and assistance at different stages of illness and recovery, and at different ages. There is good evidence that, when clinical treatment and community support co-exist, they complement each other and promote better outcomes for consumers, their families and carers. Such outcomes include tenancy stability and greater capacity to seek employment and

other community participation. While there has been considerable attention to this area at a national level and through state/territory and Commonwealth partnerships, nationally consistent models to match support to a person's needs require further development.

Develop integrated approaches between housing, justice, community and aged care sectors to facilitate access to mental health programs for people at risk of homelessness and other forms of disadvantage.

In addition to young people, some adults most at risk of developing a mental illness, for a range of reasons, cannot access services in clinics or other community settings. Ways need to be found to facilitate their access and engagement. Intervening to address mental illness may need assertive and flexible models of care—able to engage the person at a time and location that best meets their needs, and in a way that supports continuity through key transition periods.

The development of service models embedded in relevant services or locations— e.g. homelessness services and social housing initiatives, correctional facilities, residential child welfare services and workplaces, or which respond to particular events such as in the aftermath of natural disasters—will support better recognition, engagement and effective interventions. Where mental health services are provided in particular service settings, such as a correctional services facility or residential setting, it is important that there is close liaison between the mental health service providers and other workers to ensure clear communication and common understanding— for example, in relation to prisoners at risk of

self harm, and the management of those with severe personality disorders.

Lead the development of coordinated actions to implement a renewed Aboriginal and Torres Straits Islander Social and Emotional Well Being Framework.

The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004–2009* (the Framework) was developed to respond to the high rates of social and emotional wellbeing problems and mental illness experienced by Aboriginal and Torres Straits Islander (ATSI) people and communities.

The Framework was designed to complement the *National Mental Health Plan* and the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (2003–2013). It was endorsed by the Australian Health Ministers' Advisory Council (AHMAC) in 2004. The Framework emphasised a number of important areas for shared action and initiatives. These remain relevant but need to be re-visited and implemented in the new environment of joint government effort. This work will need to take into account other recent developments through COAG and other sectors relevant to a social and emotional wellbeing approach.

Most importantly, Australia is undertaking a comprehensive approach to 'Closing the Gap' of Indigenous disadvantage in health. It is imperative that these efforts prioritise mental health, social wellbeing and emotional wellbeing, as this is critical to all efforts that aim to give Indigenous Australians the same health status as other Australians.