

Mental Health: Exploring Collaborative Community Reform in South Australia



Tanya Mackay & Dr Ian Goodwin-Smith

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For further information

Dr Ian Goodwin-Smith
Director, Australian Centre for Community Services Research
E: ian.goodwinsmith@flinders.edu.au

Australian Centre for Community Services Research

Sturt Road Bedford Park
Flinders University
South Australia 5042 Australia

GPO Box 2100
Adelaide SA 5001

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Ann Crocker



Table of Contents

Executive summary & recommendations.....	5
Definitions	11
Introduction.....	14
Literature	15
Mental health: The Australian context	16
Approaches to mental health care.....	17
The Australian mental health sector	24
South Australian mental health policy	31
Homelessness and mental health	41
Summary	52
Research method	52
Findings and discussion	55
Key theme one: Stepping up – a system unbalanced.....	56
<i>Supported accommodation: The steepest steps</i>	<i>58</i>
<i>Risk averse ‘experts’: A system blockage</i>	<i>61</i>
Key theme two: Strategy and reform – connecting the parts	64
Key theme three: Fostering collaboration – integrating a person first approach	69
<i>Working together: outcomes, indicators and measures.....</i>	<i>72</i>
Key theme four: Them and us – a roadblock to recovery	75
Key theme five: Consumer and carer voice – the missing piece	79
Conclusion	82
References	84

Executive summary & recommendations

This project, 'Mental Health: Exploring Collaborative Community Reform in South Australia' involved working collaboratively with a range of sector stakeholders, consumers and carers to identify and explore the priorities for mental health reform in South Australia, focusing on opportunities and barriers in the provision of cross-sectoral service integration. The value of sustainable accommodation combined with appropriate support during the recovery journey for people living with mental illness was also explored in this research. The project explored two questions which built upon each other. These research questions were:

1. What are the community mental health and related community sector priorities for mental health reform?
2. To what extent does sustainable and high quality accommodation combined with appropriate supports contribute to the recovery journey?

One-to-one interviews were conducted with identified stakeholders related to the government and the community mental health sectors. Two focus group sessions were also held to explore consumer and carer experiences and priorities for reform from a lived experience perspective.

This research provides a consolidated account of the experiences of those that use the mental health system and work within the field. It identifies a core set of themes which continue to affect the implementation of a collaborative, integrated mental health system. Findings included that the system is fragmented and unbalanced, that it is focused on clinical approaches, and that it is a risk averse sector with a negative workforce culture issues, ongoing discrimination and stigmatisation, ineffective funding models and a lack of appropriate measures, indicators and targets. Participants advocated for a stepped, collaborative, person-centred system, with the consumer and carer voices being the most

important elements in any future reform, and were eager to engage in the work needed to achieve this goal.

The recommendations from the findings drawn from the analysis of the data gathered for this report are as follows:

Recommendation 1: Refocus on the effective implementation of a stepped system of care, rebalancing roles and resources within the mental health sector to best serve consumers at their level of need.

To implement this recommendation it is suggested that:

- the system be refocused on early intervention, prevention and community-based supports through the development of a strategic long-term plan to increase collaboration and integration within the South Australian mental health sector;
- emphasis be placed on effective implementation of a graduated stepped model, and particularly on community-based and subacute options such as Intermediate Care Centres (ICCs), crisis respite, and intensive home-based support;
- the acute and community-managed mental health sectors continue to improve collaborative partnerships;
- reform places consumer recovery goals and needs at the core of the sector and focuses on offering people access to the support they need when they need it via a flexible, open door system that allows entry and exit at various steps, rather than via an acute episode.

Recommendation 2: Facilitate an integrated system. This system must be designed to effectively connect federal and state mental health funding and services, including the National Disability Insurance Scheme (NDIS) and Primary Health Networks (PHN), a well-resourced community-managed sector, consumers and carers.

To implement this recommendation it is suggested that:

- the State Government ensures that the South Australian Mental Health Commission has the independence and authority to seek information and provide recommendations, and has the requisite resources to implement reform;
- the South Australian Mental Health Commission engages a governance structure that places representation from the community and acute mental health sectors alongside representation from consumers and carers;
- the governance structure of the South Australian Mental Health Commission ensures that the voices of all mental health sector stakeholders are equally valued and that their input and expertise is reflected in policy and reform;
- the South Australian Mental Health Commission facilitates the development of a State Charter that articulates a shared vision for integrated, recovery-oriented and consumer focused reform, endorsed by all interested parties;
- the South Australian Mental Health Commission works with consumers and carers, SA Health, the community managed sector, the NDIA and the PHNs, to inform, develop and implement an effective mental health ecosystem in South Australia that engages with broader sector reform and national policy.

Recommendation 3: Develop outcomes and indicators that facilitate consumer-centred and recovery-oriented service delivery and collaborative approaches.

To implement this recommendation it is suggested that:

- the South Australian Mental Health Commission undertakes a review of the current outcomes, targets and measurements used within the South Australian mental health sector;
- new evidence-based measures and outcomes are developed that holistically reflect consumers' individual and unique recovery journeys alongside their clinical outcomes and symptoms;
- the South Australian mental health sector commit to these outcomes via a Charter facilitated by the South Australian Mental Health Commission;
- outcomes facilitate the ongoing development of partnerships between the community and acute mental health sectors;
- outcomes reflect and develop a commitment to whole of person approaches via cross-sector partnerships that support people in managing a range of social health needs;
- the State Government allocates funding based on these outcomes and prioritises resources for effective models of community-based support.

Recommendation 4: Invest in training and facilitate the development of cross-sector knowledge and networks to challenge the stigma attached to mental illness by the workforce.

Recommendation 5: Invest in engagement with, and development of, the lived experience workforce.

To implement these recommendations it is suggested that:

- the mental health sector continues to support and implement the upskilling, support and development of a qualified and appropriately remunerated workforce;
- stronger cross-sector networks are developed through collaborative services and training;
- commitment is made to investing in appropriate training and ongoing supervision for employees to challenge stigma and discrimination, facilitate respectful consumer centred approaches, and educate the workforce about the important contribution, unique skill and expertise that lived experience and peer workers make to consumer recovery journeys;
- the unique expertise and skills of the lived experience workforce are recognised in recruitment and remuneration policies and through the provision of resources to ensure ongoing support and development opportunities;
- the peer worker role is expanded, allowing consumers access to peer workers at every level of support in a stepped system of care;
- the development of the peer workforce is facilitated via subsidised training and the infrastructure and resources needed to provide ongoing support and training.

Recommendation 6: Develop stronger avenues through which the voices of consumers and carers can be heard, and place these at the centre of policy and service development.

To implement this recommendation it is suggested that:

- system reforms are undertaken via a process of co-design, in partnership with consumers and carers;
- consumers and carers are engaged in an expert role as part of the governance structure of the South Australian Mental Health Commission and within SA Health;
- the use of consumer and carer participation is standard practice in governance, development, evaluation and tendering with regards to programmes and services in the mental health sector;
- expert knowledge and input from mental health consumers and carers is sought across sectors to ensure representation of the consumer voice in all social health issues that factor into an individual's mental wellbeing;
- appropriate remuneration is provided to consumers and carers in recognition of their contribution in consultation or advisory roles;
- investment is made into implementing consumer- and carer-centred policies and training across the South Australian mental health sector to ensure the integration of consumer and carer input is respected and supported;
- investment is made to ensure that consumers and carers engaged in expert advisory or consultation roles have access to ongoing support, peer supervision and development opportunities to enhance their skills and contributions to policy and practice.

Definitions

For the purpose of this project the following definitions have been used. This report acknowledges that these meanings are debated and recognises the varied experiences of those that use and work within the sector in relation to this.

Consumer: A person experiencing mental illness, who has received or is utilising treatment and support from a GP, public or private mental health service, or community-managed organisation.

Carer: Someone who provides support and care for another experiencing mental illness. A carer may be the person's wife, husband, partner, son, daughter, parent, neighbour, friend or, in some cases, their child or children. It doesn't matter how many hours are spent each week providing support. Carers may live with the person they are caring for, providing assistance with daily needs, or may visit the person regularly. Carers are people who invest time, energy and support, generally in an unpaid capacity. Some carers may receive Centrelink benefits to enable them to continue in their caring role. Carers are often 'hidden', or do not see themselves as a carer.

Lived experience: The knowledge and understanding a person gains when they have lived through something is called lived experience. When we talk about people with mental health lived experience, we mean people who have or do live with mental illness, and family or friends who have supported or who are supporting someone living with mental illness.

Peer work/er: Consumers or carers who have a lived experience of, or care/have cared for someone with, mental illness and are engaged to provide support for

others. Peer workers are increasingly employed by mental health services to provide peer support. Peer workers should have a Certificate IV Peer Worker.

Acute care/service: Acute mental health services provide specialist psychiatric care for people who present with acute or crisis episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The treatment effort is focused on symptom reduction with a reasonable expectation of substantial improvement. In general, acute services provide relatively short-term treatment.

Clinical: Services that focus on the treatment and or reduction of clinical symptoms and are usually undertaken by someone in a qualified, professional role such as psychiatrists, doctors and mental health nurses.

Community-based services: Service and support outside of hospitals or acute settings to people experiencing mental illness. These can include clinically-focused services, psychosocial services, outpatient services, domiciliary and other visiting services, and consultation and liaison services to general practitioners, primary health care and private sector providers.

Community-managed mental health sector: Non-government organisations that provide community-based support services for people affected by mental illness and their families and carers.

Community mental health services: Government run specialist mental health services that deliver a range of acute interventions and ongoing support services in the public sector.

Adapted from:

Department of Health, *Fourth national mental health plan 2009-2014*,
Commonwealth of Australia, Canberra

Mind Australia, Helping Minds, Private Mental Health Consumer Carer Network
(Australia), Mental Health Carers Arafmi Australia and Mental Health Australia
2016, *A practical guide for working with carers of people with a mental illness*,
Australia

Introduction

An increasing body of evidence has demonstrated the positive contribution that mental health systems with strong community-managed sectors have on the recovery journeys of those experiencing mental illness. Collaborative, integrated mental health support has been established as a core component in the development of mental health systems that best address the complex and interrelated social health needs of consumers and those that support them. This project, 'Mental Health: Exploring Collaborative Community Reform in South Australia' involved working collaboratively with a range of sector stakeholders, consumers and carers to identify and explore the priorities for reform in South Australia, focusing on opportunities and barriers in the provision of cross-sectoral service integration. The value of sustainable accommodation combined with appropriate support during the recovery journey for people living with mental illness was also explored in this research. The project explored two questions that built upon each other. These research questions were:

1. What are the community mental health and related community sector priorities for mental health reform?
2. To what extent does sustainable and high quality accommodation combined with appropriate supports contribute to the recovery journey?

In order to establish a sound understanding of the mental health sector in South Australia, an in-depth literature review was undertaken. Following this, one-to-one interviews were conducted with identified stakeholders relevant to the government and the community mental health sectors. Two focus group sessions were also held to explore consumer and carer experiences and priorities for reform from a

lived experience perspective. Following analysis the draft recommendations were reviewed in a collaborative roundtable process with participants, project partners and other key stakeholders, allowing them the opportunity to provide feedback. This was then incorporated into the final recommendations and report.

It was evident early in this research that the findings would not be new to those familiar with the mental health sector in South Australia. Instead, this project would provide a consolidated account of the experiences of those that use the mental health system and work within the field. It brings together a core set of themes that continue to affect the implementation of a collaborative, integrated mental health system. Findings included that the system is fragmented and unbalanced, focused on clinical approaches, and that it is a risk averse sector with a pervasive negative workforce culture, ongoing discrimination and stigmatisation, ineffective funding models and a lack of appropriate measures, indicators and targets. Participants advocated for a stepped level, collaborative, person-centred system, with the consumer and carer voices being the most important elements in any future reform. They were eager to engage in the work needed to achieve this goal.

Literature

A combination of narrative and systemic approaches were utilised to conduct the literature review for this project. The review aims to summarise the body of work already undertaken in this area, as well as provide an overview of policy and relevant theories in Australia, and more specifically in South Australia, that underpin the mental health sector. The review was also informed by consultation with key government and non-government stakeholders. Electronic searches utilising Google Scholar and databases were conducted focusing on the key themes of community mental health, mental health service, collaboration, integration, stepped care, homelessness, accommodation, deinstitutionalisation,

peer work, recovery model and consumer-centred care. These searches were limited to sources from 1950 to 2016 and a 'snow ball' method, in which sources were identified from reviewed literature, was used in order to explore interconnected concepts and references. The sources drawn on for this literature review include:

- peer-reviewed journal articles
- 'grey' literature (e.g. government and non-government reports or policy documents and reports from academic institutions or research centres in Australia and overseas)
- electronic literature and practice resources from government and non-government organisation websites and print materials.

Mental health: The Australian context

The prevalence of people experiencing mental illness is increasing (World Health Organisation (WHO), 2013). Mental health, incorporating a person's emotional, social, and psychological wellbeing, affects how people feel and behave as well as their interactions and ability to function within social and institutional structures (WHO, 2014). When looked at holistically, an individual's mental health incorporates and is influenced by a range of socio-emotional and biological factors, including life experiences, genetics, brain chemistry, and social conditions such as unemployment and homelessness (Council of Australian Governments (COAG), 2012; National Mental Health Policy (NMHP), 2008; WHO, 2014). A complex interaction of these various factors all contribute to a person's mental wellness. However, in a clinical context, a mental health disorder is defined as a 'significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning' (American Psychiatric

Association, DSM-5, 2013, p.20). The WHO estimates that up to 450 million people worldwide are experiencing some form of mental health issue (COAG, 2012; WHO, 2013). The experience of mental illness can be associated with significant distress or disability in social and occupational activities, and has also been linked to increased rates of physical ill health (American Psychiatric Association, DSM-5, 2013, p.20; COAG, 2012; Fourth National Mental Health Plan (FNMHP), 2009-2014). It has been estimated that mental illness accounts for approximately 12% of the global burden of disease (WHO, 2003a, p. 02), and that in Australia an estimated 45.5% of adults between the ages of 16 and 85 experience a mental health disorder at some stage of their life (Australian Bureau of Statistics (ABS), 2007; Slade, Johnston, Teesson, Whiteford, Burgess, Pirkis & Saw, 2009). In a 12 month period, approximately one in five people in Australia experience a mental health disorder (FNMHP, 2009-2014; Slade et. al., 2009). Notably, prevalence is higher in woman and anxiety disorders affect the largest proportion of people (14.4% in a 12 month period) (ABS, 2007; FNMHP, 2009-2014). This is followed by affective disorders (including depression), whilst substance abuse accounts for 5.1% of mental illness reported (ABS, 2007; FNMHP, 2009-2014).

Approaches to mental health care

Approaches to mental health care have historically been clinically focused, drawing from the disciplines of medicine and psychiatry (Doessel, 2009; 2004; Richmond & Savy, 2005; WHO, 2003a). Eighteenth and early nineteenth century discourses constructed those experiencing mental illness as, 'mad, insane, criminal and deviant' (WHO, 2003a, p.03-04). This underpinned the development of structures such as asylums to 'manage' those who did not conform to dominant social ideals (WHO, 2003a, p.03-04). Early approaches were aimed at treating or curing people, utilising a variety of physical, pharmacological, and psychological methods (WHO, 2003a, p. 21-22). In the 20th century the increasing acceptance

of psychosocial treatments shifted focus to recovery, consumer led/centred treatment and early intervention and prevention (Doessel, 2009; Richmond & Savy, 2005; WHO 2003a, p.03-04). This most evidently manifested in the deinstitutionalisation of mental health services and other health and welfare institutions such as disability services and orphanages (Doessel, 2009; Richmond & Savy, 2005; WHO 2003a, p.03-04).

Globally, the policy of deinstitutionalisation (that is, the closing/downsizing of acute psychiatric services, the reduced instances of inappropriate admission, ensuring discharge of patients suited to and prepared for life outside of institutionalised living), and the provision of community mental health services to support these processes has been driven by an increasing recognition of psychosocial supports and a push towards community-based mental health services (Doessel, 2009; Richmond & Savy, 2005; WHO, 2003a). This shift has in part been driven by consumer rights advocates who have helped reduce the stigma associated with mental illness, argued for more person-centred approaches, and highlighted the ineffectiveness and sometimes negative outcomes of traditional mental health care practices (WHO, 2003a; Richmond & Savy, 2005).

The deinstitutionalisation of mental health services in Australia accelerated during the 1980s and gathered momentum in the National Mental Health Strategy (originally released in 1992), which outlined a shift to more community-based care (2004). This policy and its associated strategic plans underpinned the closure of standalone psychiatric hospitals, the reduction of inpatients in the remaining standalone psychiatric hospitals, and a decrease of acute beds in hospitals for mental health patients (Carter, Burke & Moore, 2008; Doessel et al., 2015; Richmond & Savy, 2005). This has resulted in an increasing number of mental health services provided by a community mental health sector (Doessel, 2009; Whiteford & Buckingham, 2005). The term 'community mental health' has been

used to describe both clinical services provided outside of hospital settings, and psychosocial services provided in community settings by non-government organisations. What defines a service as community-based is debated. It has been suggested that hospital outpatient clinics, non-hospital government services, and non-government organisations (who provide mental health care assistance such as crisis intervention, treatment services, programmes, and outreach or prevention, detection and intervention) all provide community-based mental health services (Doessel, 2009; Whiteford & Buckingham, 2005).

In an effort to increase access and quality of appropriate care, WHO recommends the implementation of:

... community-based mental health and social care services; the integration of mental health care and treatment into general hospitals and primary care; the continuity of care between different providers and levels of the health system; effective collaboration between formal and informal care providers and the promotion of self-care, for instance, through the use of electronic and mobile health technologies' (WHO, 2013, p.14).

The policy shift from institutionalised care towards a sector built primarily on community mental health services is reflected in the current National Mental Health Policy (2008) which aims to ensure consumers are supported via a variety of connected services ranging from primary health care and acute mental health services through to community mental health services delivered by both the government and non-government sectors (FNMHP, 2009-2014; NMHP, 2008; Whiteford & Buckingham, 2005). With clients' needs being the focus of service delivery, the national goal is 'for people with mental health problems and mental illness to have access to the right care at the right time', and for services to be provided in a manner that places prevention and early intervention as a priority for sustainable recovery outcomes (FNMHP, 2009-2014; NMHP, 2008).

This shift towards a mental health system with a robust community sector reflects international best practice as outlined by WHO, which suggests that effective

mental health systems should be built on a strong community sector where, comparatively, the need is higher and the cost lower than in the acute, long-term or clinical-based service options (Anderson, Dayson, Wills, Gooch, Margolius, O'Driscoll, & Leff, 2000 Costello, Thomson & Jones, 2013; WHO, 2007). Furthermore, it has been proposed that effective systems engage with collaborative partnerships to facilitate integrated models of practice, not only between community and clinical mental health services, but with the broader spectrum of social services that support those experiencing a mental illness (England & Lester, 2005). In Keleher's continuum model of shared mental health care for the Australian context, collaborative practice and integrated service delivery are described as the strongest forms of partnership in a community-based system which more holistically supports the complex needs of those experiencing mental illness (2006, p.92). Konrad's (1996) work on multidimensional models of human services supports a collaborative approach, with fully integrated services working more holistically with people, addressing interconnected needs rather than specific problems, and engaging with people as members of families and communities.

Consumers supported by systems built on collaborative, integrated community services have notably better recovery outcomes and quality of life than those treated in institutional care (Anderson et al. 2000; Carter, Burke & Moore, 2008; England & Lester, 2005). Despite this, the level of resources for community services and collaborative practices does not reflect the savings realised from the reduction in demand for institutionalised services which they deliver (Doessel, 2009; Doessel et al., 2015; Richmond & Savy, 2005; Whiteford & Buckingham, 2005; WHO, 2007). The national inquiry into the human rights of people with mental illness specifically identified that savings attributed to deinstitutionalisation in Australia had not been redirected into community-based care, resulting in the community-managed sector being unable to operate effectively due to a lack of funding (Human Rights and Equal Opportunity

Commission, 1993). This legacy of an underfunded community-based mental health sector has acted as a roadblock to early intervention, increasing acute admission in times of crisis and putting community mental health services under strain (WHO, 2007). Consequently, there is an increased demand for expensive and often inappropriate beds in hospitals and institutions, which become 'clogged' with consumers unable to step down due to insufficient community services or networks on discharge (NMHC, 2014; WHO, 2007).

Person-centred and recovery-oriented approaches, developed from the same consumer movement that underpinned the closing of mental health institutions and the rise of community-based services, are also core concepts in national and international approaches to improving mental health policies and systems (Davis & Gray, 2015; FNMHP, 2009-2014). Person-centred approaches are utilised across the social welfare field and share similar core principles. These include respecting and including people and their individual goals, wants, and dreams, rather than just their professionally assessed needs in intervention/recovery plans (Beresford et al., 2011, p.50; Davis & Gray, 2015); the inclusion of any people with important or significant relationships to and with the person in their recovery plans (Beresford et al., 2011, p.50; Davis & Gray, 2015); and the provision of support that evolves and allows as much choice and control by the person as possible, and services implemented with a strengths-based focus, and attention to inclusion, dignity and respect (Beresford et. al., 2011, p.50).

Further to this, concepts of recovery-oriented services are key components in international and Australian mental health policies and strategies (Davis & Gray, 2015). Shepherd, Boardman, and Slade (2008) note that a recovery-based approach can be considered the current best practice model for systems and services. New Zealand, the United States, Canada, and the United Kingdom have all demonstrated success with embedding recovery at the core of mental health policies and reforms (Shepherd, Boardman, & Slade, 2008). Recovery-oriented

approaches engage the key components of person-centred practice, which also stemmed from the consumer/survivor movement of the 1980s, and which was based on self-help, empowerment, and advocacy (Slade, 2009). Recovery in the mental health context can be defined as:

... a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness' (Anthony, 1993, p. 527).

Additionally, clinical recovery, where a person does not experience identifiable clinical symptoms of a diagnosed mental illness, has been differentiated from personal recovery, which is a unique experience for every person and is built from their individual sense of wellbeing and engagement with their daily life, satisfaction, personal values, and goals (Anthony, 1993; Davis & Gray, 2015; Onken et al., 2007; Slade, 2009). Of note is the documented sentiment among mental health consumers that, unlike personal recovery, the experience of a 'complete' clinical recovery is unrealistic due to the episodic nature of mental illness (Davis & Gray, 2015; Slade, 2009). It has been proposed that to facilitate personal recovery, what is required is a self-directed, person-centred, and holistic model which engages with all aspects of a person's life, including community, relationships, peer supports, and any services (mental health, housing, employment, etc.) that support a person in their unique and complex experience (Davis & Gray, 2015; Slade, 2009). Recovery-oriented services are flexible and strengths-based, engaging with principles of empowerment, respect and hope whilst also emphasising the responsibilities of both service providers and consumers in the recovery process (Davis & Gray, 2015; Onken et al., 2007; Slade, 2009). Both the COAG Expert Reference Group on Mental Health Reform (CERG) (2013) and the NMHC (2014) have identified a need to better engage with personal recovery journeys, and this is evident in their recommendations for

more holistic system measures. It has been recognised that the mental health sector must rebalance clinical symptom and cost/efficiency measures with outcomes, targets and measures that engage the range of social health needs impacting mental wellness, and better encapsulate the complexity of mental illness and recovery (CERG, 2013; NMHC 2014).

The concept of peer support is also increasingly being embedded in mental health care policies, with peer support workers being described as 'someone who is living well with, [or has experienced] a mental illness and who has been engaged to share their experience to assist and support other people with a mental illness' (Courage Partners, 2011, p. 99; Mead & MacNeil, 2006; Nestor & Akins, 2006). Peer workers may operate in either a paid or voluntary capacity, and are primarily located within the community, non-government, and consumer-led sectors (Mead & MacNeil, 2006; Nestor & Akins, 2006). Literature suggests that the benefits of peer workers are numerous, for both the consumer and worker. Implementation of peer support has been noted to reduce hospital admissions, increase levels of social inclusion and community connection, and contribute to positive outcomes in relation to quality of life indicators for consumers. Peer work has also been found to be financially empowering, contributing to increased levels of self-esteem and enhancing the ongoing recovery journey for peer workers themselves (Davidson, Bellamy, Guy, & Miller, 2012; Davidson, Chinman, Kloos, Weingarten, Stayner, & Tebes, 1999; Davidson, Chinman, Sells, & Rowe 2006; Gallagher & Halpin, 2014; Lawn, Smith, & Hunter, 2008; Repper & Carter, 2011; Siskind, Harris, Pirkis, & Whiteford, 2012). Within Australia, peer work has largely been relegated to an advisory or consultancy role, and as such does not fully draw on the potential benefits of the capabilities that those with lived experiences have gained throughout their recovery journey (Glover & Turner, 2008). In an effort to ensure the ongoing development of an effective, accountable, and sufficiently supported peer workforce, recommendations for reform have included role clarity, increased training and certification, review and restructure of staffing to accommodate peer

workers and associated costs, and the development of supervision benchmarks and procedural guidelines (FNMHP, 2009-2014; Gallagher & Halpin, 2014; The National Review of Mental Health Programmes and Services, 2014; Oades, Deane, & Anderson, 2012).

The Australian mental health sector

The primary responsibility for mental health services in Australia falls to state governments, but these services are informed and have been reformed by a number of national policies and directives. The National Action Plan on Mental Health (2006-2011), released by COAG, focused on providing a five-year framework for an interconnected system based on collaboration between government, private, and non-government services, and increasing access to and engagement with community supports. This integrated approach was aimed at reducing the number of people experiencing mental illness falling through gaps in the system. The framework contained the following five strategic priorities: promotion, prevention and early intervention, integrating and improving the care system, participation in the community and employment and increasing workforce capacity, and coordinating care (COAG, 2006). The plan also outlined individual implementation plans for both the Commonwealth and the states which further highlighted the increasing recognition of community-based services. Notably, South Australia's plan outlined funding to improve access to acute and community-based clinical services and psychosocial support services, such as home-based support, social skill development, assistance with medication management, and support to engage with recreation, training education and employment (COAG, 2006). Peer support programmes were also allocated funding to provide support, education, and advocacy (COAG, 2006). The National Mental Health Policy (2008) aimed to develop a mental health sector that enabled recovery, prevented onset, prioritised early intervention, and

increased access to appropriate support and treatment to allow people experiencing a mental illness to participate to their full potential within their community (NMHP, 2008). This was based on people having 'the right care at the right time' (NMHP, 2008, p.16) via an inter-connected sector including acute, clinical, and community services. Building on the Mental Health Strategy (1992), the NMHP (2008) further emphasised the importance of community-based mental health services and proposed a need for increased engagement with a cross-sector integrated approach (NMHP, 2008). The policy suggested that by strengthening collaborative partnerships between clinical, psychosocial, community-managed, and government services in the mental health sector, and building capacity for partnerships with housing, employment, education, youth affairs, police, community and disability services, corrective services, and alcohol and drug services, a more cohesive system could be developed (NMHP, 2008, p.19). This system would accordingly be better placed to positively support and contribute to sustainable recovery for those experiencing mental illness (NMHP, 2008, p.19). The National Standards for Mental Health Service (2010) draw from the National Mental Health Policy and are applicable to clinical and psychosocial services provided by primary care, government, and non-government agencies. These standards aim to guide services to ensure appropriate practice and ensure the provision of continually improving, quality mental health services for consumers. The key principles of the standards advocate a client-centred approach and outline that care will be delivered in accordance with the nine domains of the 'Key Performance Indicators for Australian Public Mental Health Services' (2005): effectiveness, appropriateness, efficiency, accessibility, continuity, responsiveness, capability, safety, and sustainability.

The Fourth National Mental Health Plan (2009-2014) built on both the COAG National Action Plan 2006–2011 and the National Mental Health Policy (2008). The plan further demonstrated a national commitment to a more integrated sector, focusing on strengthening the relationships between primary, clinical, and

psychosocial mental health service providers at the acute and community levels, as well as increased collaboration across portfolios. This cross-sector engagement between mental health services and areas such as housing, justice, education, employment, community, and aged care was articulate within the plan's framework of a national model focused on person-centred, recovery-oriented care that is accessible, continuous, and wraps around those experiencing mental illness to promote social inclusion and community participation (Davis & Gray, 2015). The Roadmap for National Mental Health Reform endorsed by COAG in 2012 continued to advocate for this approach, proposing that in order for the best possible recovery outcomes to be achieved, consumers must have access to a range of flexible, client centred, integrated services when needed, and that these should be provided by partnerships between government, private, and non-government agencies in both clinical and community settings (COAG, 2012). Additionally, the Roadmap outlined support for further cross-sector collaboration, stating 'those in the fields of health, community services, education, employment, housing, justice and corrections need to work more effectively with each other and with individuals, families and carers, to help people with mental illness to recover and maximise their wellbeing' (COAG, 2012, p.11), and that 'governments need to improve the effectiveness of their systems by improving the planning, organisation and integration of relevant services and support' (COAG, 2012, p.11).

In 2014 the National Mental Health Commission undertook a review of Australian mental health programmes and services and the resulting report, 'Contributing Lives, Thriving Communities', was developed to inform the development of the Fifth Mental Health Plan. The core recommendation of this report advocated strongly for an increased focus on community mental health services and proposed that, although current national policy engages with the concept of an integrated, collaborative system in practice, it is fragmented and functions as 'a collection of often uncoordinated services introduced on an ad hoc basis, with no

clarity of roles and responsibilities or strategic approach' (NMHC, 2014, p.04).

The report also noted the need to:

- redesign the system to focus on the needs of users rather than providers in a person-centred approach;
- shift away from a one size fits all approach;
- rebalance expenditure away from acute services which indicate system failure and invest in evidence-based services including innovative technologies to increase prevention and early intervention;
- engage with holistic, recovery-based community support that facilitates cross-sector integration and collaboration, for example with housing, employment, education, and training;
- repackage funds spent on the small percentage of people with the most severe and persistent mental health problems who are the highest users of the mental health dollar to purchase integrated packages of services which support them to lead contributing lives and keep them out of avoidable high-cost care;
- reform our approach to 'supporting people and families to lead fulfilling, productive lives so they not only maximise their individual potential and reduce the burden on the system but also can lead a contributing life and help grow Australia's wealth' (Commonwealth of Australia, 2015; NMHC, 2014).

The Federal Government's response to this review was released in November 2015, and aimed to engage with the recommendations provided in the report, proposing that strengthened leadership in the sector was required nationally to implement a 'redesigned, redirected, rebalanced and repackaged' system (Commonwealth of Australia, 2015, p.07). Despite acknowledging the recommendation of a need to shift focus from acute episodes of illness and crisis support to early intervention and prevention, the Government rejected the

Commission's proposal to reallocate funds in forward estimates from the public hospital system to alternative mental health services (Commonwealth of Australia, 2015, p.10).

The proposed policy is built on a person-centred, recovery-orientated approach across the lifespan and will underpin a system operating from a local/regional base to deliver services via a stepped care model (Figure 1) with emphasis on new digital supports (Commonwealth of Australia, 2015, pp.09-10). Services will be locally planned and commissioned via the existing PHNs in an aim to integrate services and promote collaborative approaches amongst service providers (Commonwealth of Australia. 2015. p.11). Notable changes to existing services include the gradual restructure of primary mental health care services, such as the Better Access programme, Allied Psychological Services (ATAPS), Mental Health Services in Rural and Remote Areas (MHSRRA), and the Mental Health Nurse Initiative, in favour of what is described as 'alternative, less costly models of evidence based service delivery' (Commonwealth of Australia, 2015, p.14), such as the digital mental health gateway and New Access programme (Commonwealth of Australia, 2015, p.11). New Access is a service for adults with mild to moderate depression and anxiety who are not currently accessing existing mental health services, aiming to improve mental health via coaches who assist with Low Intensity Cognitive Behavioural Therapy. The programme is based on a model of care known as 'Improving Access to Psychological Therapies' (IAPT) developed in the United Kingdom (Ernst & Young, 2015). Additionally, programmes such as the youth mental health service, Headspace, will be integrated at a regional level via the PHNs in order to reduce duplication and increase collaborative, integrated, consumer-centred service responses (Commonwealth of Australia, 2015).

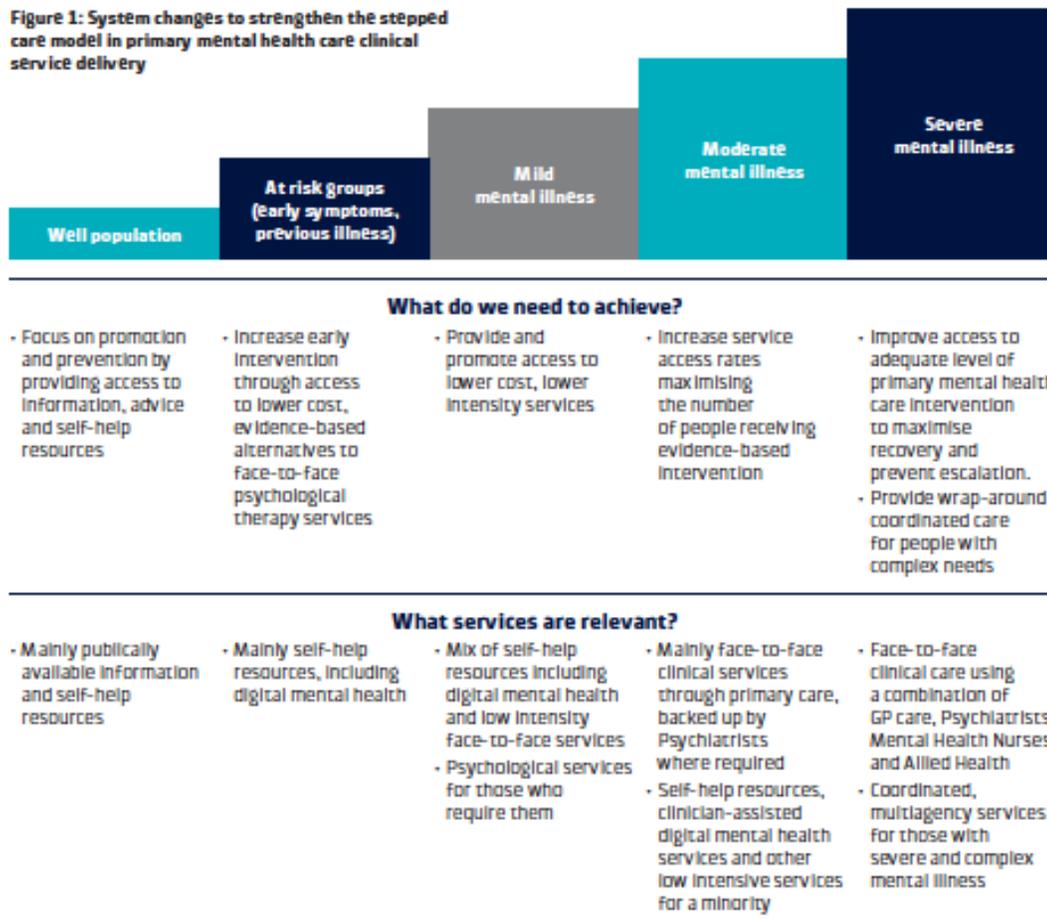


Figure 1. Source: Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes & Services. Commonwealth of Australia, (2015).

The move towards a person-centred approach as noted in the Government’s response reflects the influences of health care policy more broadly. The growth of consumer-directed care models internationally is significant, and it is evident in Australia’s development of a National Disability Strategy (KPMG, 2014), and the NDIS. These policies will have a direct and substantial effect on reforming the mental health care landscape. Traditional funding for disability support is provided via a block funding model to both government and non-government providers who

deliver a range of set services (KPMG, 2014). The NDIS model, underpinned by consumer directed care, provides those with disabilities with an annual individual funding sum from a central government agency to 'purchase' a variety of government and non-government specialist services of their choice (Davis & Gray, 2015; MHA, 2014). This approach, in which services will no longer be driven by agencies and providers but instead market forces and consumption, is proposed to positively enhance consumer independence. Additionally, the Productivity Commission suggests, 'the poor fit of the emerging community mental health system and the traditional clinically-oriented mental health system, means that the NDIS would be a more appropriate umbrella for the provision of community support' (2013, p.27).

The Productivity Commission estimates that under the proposed NDIS model, only 60,000 of the 489,000 people identified as experiencing a serious mental illness will qualify for a NDIS package of support based on the proposed criteria requiring to prove a 'permanent impairment', or more specifically in the mental health context, a 'serious and persistent mental illness with complex interagency needs' (Mental Health Council of Australia, 2013, p.01; Productivity Commission, 2011). The Mental Health Council of Australia (MHCA) have proposed that, while not all 489,000 people estimated to be experiencing mental illness will require a package, the qualification criteria is confusing and will result in a large number of people who require support being excluded from accessing individualised packages (2013). Furthermore, the Productivity Commission's (2011) estimate that only 10% of those who qualify will require the most intensive levels of support has been noted by MHCA to underestimate the level of need for support and the complexity of mental health issues (MCHA, 2013). Concern has also been raised with regard to consumers who will not qualify for individual funding and their continued access to existing services and supports (which have been noted to already be insufficiently coping with demand), given the expected reduction in service funding to accommodate expenditure for the NDIS model (MCHA, 2013).

South Australian mental health policy

In 2014–2015 approximately 18.3% of the South Australian population reported experiencing a long-term mental health or behavioural problem (ABS, 2015). It is estimated that the number of people in the Adelaide region with a mental health plan (8%) is slightly higher than the national average (Adelaide PHN, 2015), with a majority of these being for mood disorders such as depression and anxiety (ABS, 2015). When compared to the national average, the population of the Adelaide region is estimated to experience higher rates of high or very high psychological distress (Adelaide PHN, 2015). Furthermore, in the past decade South Australia has consistently spent more per capita on mental health-related medication via the Pharmaceutical Benefits Scheme and the Repatriation Pharmaceutical Benefits Scheme (PBS/RPBS) than any other state (Mental Health Services in Brief, 2014). The Australian Institute of Health and Welfare (AIHW) reported that South Australian community-delivered and in-hospital public sector mental health services accounted for approximately 5.5 million service contacts, equating to services provided to about 301,000 patients in 2011–2012 (Mental Health Services in Brief, 2014, p.10). KPMG reported that between 2011–2012 and 2013–2014 there was a 7% increase in mental health related presentations in South Australian emergency departments (KPMG, 2015, p.08). The average length of stay for consumers in emergency departments and inpatient beds also progressively increased during this period (KPMG, 2015). South Australia reports the lowest rate (9.3%) of readmission within 28 days of discharge from an acute service, and the second highest number of community-based contacts with government community mental health services (371.8 per 1000 population) (Mental Health Services in Brief, 2014, p.10). In the early years following the National Mental Health Policy, South Australia was slow to allocate funding to the community-managed sector, with 2003 figures highlighting the lowest expenditure in the nation (2.1%) (Department of Health and Ageing, 2005, p.36). The investment was subsequently increased, with 2010–2011 figures

showing an 11.5% expenditure (Department of Health and Ageing, 2013, p.132). However, concerns exist as to the ongoing development of the sector with funding cuts to significant community-based programmes such as IHBSS and Crisis Respite Centres (CRCs).

South Australia began to move towards the deinstitutionalisation of service provision with the implementation of the Mental Health Act 1976–1977, which outlined the powers allocated to medical practitioners to detain people experiencing mental health issues, and detailed measures to ensure more scrutiny into how those engaged in institutional settings were treated (Doessel, Scheurer, Chant, Harvey & Whiteford, 2015; Richmond & Savy, 2005). This Act was driven by a growing local and global focus on ensuring and balancing the rights and safety of the consumer with the wellbeing and safety of the public, with liberty, social justice and respect becoming core concepts of service (Anthony, 2000; Davidson et al., 2006; Fisher and Chamberlin, 2004; Richmond & Savy, 2005). The current South Australian Mental Health and Wellbeing Policy (SAMHWB) has continued to reflect national policy, outlining a system built on cross-sector partnership, community mental health services, and person-centred, recovery-oriented models (2010). The Stepping Up Report released by the South Australian Social Inclusion Board (SASIB) in 2007 informed this policy significantly (SAMHWB, 2010). The report provided a five-year action plan for mental health and reflected broader shifts in social welfare policy, recommending working from a person-centred, recovery-orientated approach with specific early intervention, prevention, and stigma/discrimination reduction targets (SASIB, 2007). Most significantly, the report proposed a new stepped system of care in the sector, with community mental health at the core (Figure Two) (SAMHWB, 2010; SASIB, 2007). This stepped system was designed to ensure a sufficient volume of continued care at various intervention levels, and to facilitate an efficient, supported transition between these to reduce increasing and reoccurring presentations of consumers at acute, hospital-based services (SASIB, 2007).

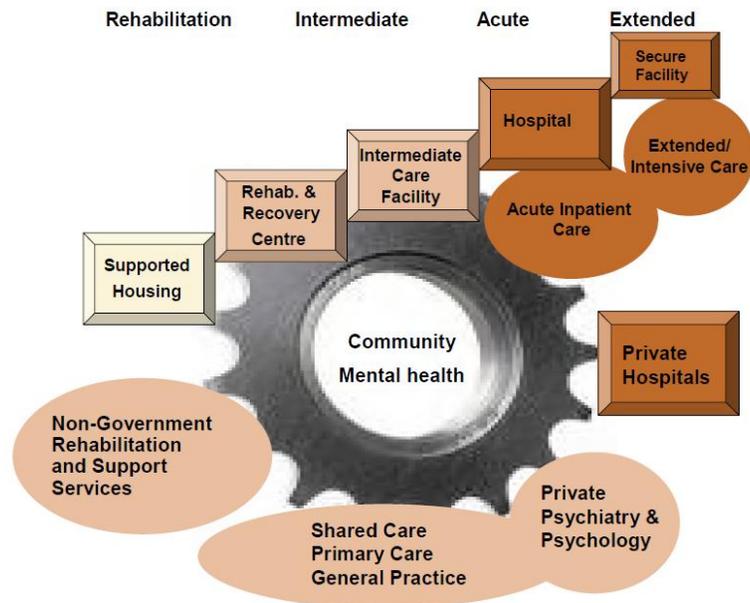


Figure 2. Source: Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007–2012, p.32.

The facility-based steps were graduated from least to most intensive, and accordingly the most cost efficient to the most expensive (SASIB, 2007). This was based on the principle that the most appropriate service approach is one which provides people experiencing mental health issues access to support and allows them to live in their own homes or communities where possible (SASIB, 2007). Supported housing was the least intensive step of the model, and was proposed as an option for those with mental illness who struggle to maintain private accommodation for a variety of reasons (SASIB, 2007, p.30). This accommodation was to be a combination of allocated public housing places (approximately 350 places) for those with mental illness and clustered housing, that is groups of units supported by staff 24 hours a day (approximately 120–150 places) (SASIB, 2007, p.30). Those residing outside of these clusters would

receive clinical and psychosocial support at home via partnerships between service providers (SASIB, 2007, p.30).

The next step was rehabilitation and recovery centres for those who needed more intensive support than could be provided in supported accommodation (SASIB, 2007, p.30). The report recommended 60 to 80 beds be allocated to such centres, but suggested that achieving the higher end of this quota should not take priority until an effective, functioning intermediate care sector was implemented (SASIB, 2007 p.30). The intermediate care step was proposed as a step down from acute hospital services, acting as an early intervention point for those who may require higher levels of care or need to be transitioned out of acute settings into community supports (Health Outcomes International (HOI), 2013a; SASIB, 2007, p.31). At the time of the report there were no facilities fitting the intermediate support criteria in South Australia. In response, the Stepping Up Report recommended that to reduce pressure on acute services and increase sustainable transitions into community living, the sector should fund and implement approximately 90 places for intermediate subacute options for consumers based on recovery-oriented service models (SASIB, 2007, p.31). This process was undertaken with ICCs implemented concurrently with the closing of metropolitan beds (SASIB, 2007, p.31).

An evaluation of the effectiveness of the implementation of ICC-based services demonstrated measurable success and recommended that the South Australian Government should continue to support the service model (HOI, 2013a, p.01). Not only did consumers report that ICCs had contributed positively to their recovery journey, the evaluation suggested that the implementation of the centres had resulted in reduced lengths of stay and reoccurring presentations at hospitals in addition to increased community mental health contacts (HOI, 2013a, pp. 04, 46 & 53). This reflects a study which reviewed a subacute crisis house facility in Brisbane and found that consumers utilising the service spent fewer days in

hospital. A cost analysis highlighted that this resulted in significant cost savings to the system (Siskind, Harris, Kisely, Brogan, Pirkis, Crompton, & Whiteford, 2013). An evaluation of two regional ICCs in South Australia, using a collaborative, non-government-managed approach, also demonstrated the positive outcomes of the subacute level of care (Martinez, Walker-Jeffreys, Muyambi & Taylor, 2015). This evaluation found that the integrated clinical and psychosocial approach of these services not only contributed to reduced hospital admissions, but that consumers reported them as being a beneficial support in their recovery journey that contributed to an increased ability to manage their mental health (Martinez, et. al., 2015). However, a KPMG evaluation of South Australian mental health services did not demonstrate these same outcomes, with their analysis of the previous four years admission data suggesting that the lengths of stay had actually increased. In summary, KPMG noted that, 'if the intended purpose of ICCs was to reduce the length of stay for consumers in emergency department or inpatient settings this had not occurred' (KPMG, 2015, p.18). This evaluation did note the value of ICCs and argued for a restructuring of the system in addition to stating that 'no additional adult acute mental health inpatient beds are required at present' (KPMG, 2015, p.03).

Allison, Bastiampillai, and Goldney (2014) note concerns with a shift towards increasing community subacute options at the expense of acute beds in South Australia, suggesting that, although Siskind et. al.'s (2013) study showed positive short-term outcomes and cost effectiveness, when examined over the long term the participants of the Brisbane programme were more likely to demonstrate relatively higher use of hospitals. Additionally, following their engagement with the subacute care service, the participants of the Brisbane programme were more likely to present at an emergency department (Allison, Bastiampillai, & Goldney, 2014). However, it can be argued, as outlined in KPMG's and HOI's evaluations, that this increased rate of hospital presentation could be attributed to ineffective implementation of the broader stepped model, with the insufficient availability of

step down options and ongoing community psychosocial supports upon exiting subacute care resulting in reoccurring acute crisis (HOI, 2013a; KPMG, 2015). It has been proposed that those who have been engaged in subacute care options may also re-present due to a higher engagement with services, and accordingly a greater likelihood of referral back to acute care due to increased surveillance and support when early symptoms are detected (Lee, Castella, Freidin, Kennedy, Kroschel, Humphrey, Kerr, Hollows, Wilkins, & Kulkarni, 2010). The conflicting data about the success of subacute, community-based care suggests further research into the area is needed, and the development of more holistic outcome measurement is required. Notably, despite demonstrated beneficial recovery outcomes and ongoing evidence supporting mental health systems centred on community-based stepped care models, a reallocation of ICC beds to the acute sector was announced in October 2015 (Snelling, 2015a). It could be argued that this ignores a significant body of evidence that advocates the effectiveness and efficiency of collaborative, community-based approaches and a need to rebalance mental health services from a clinical or acute focus to one that better supports the broad range of social health needs that affect and are affected by an individual's mental health.

The most intensive steps in the model were acute hospital beds and secure care facilities (SASIB, 2007, p.31). Acute beds support those in immediate crisis and those unable to safely remain in the community, whilst secure accommodation is an appropriate option for those unable to safely remain in the community and needing longer term support (SASIB, 2007, p.31). Secure accommodation was proposed as a more cost efficient and person-centred option, with the report stating that long-term beds in hospital settings were no longer appropriate (SASIB, 2007, p.31). At the time of the report, South Australia had more acute beds on average per 100,000 than the national average, and it was recommended that these be reduced and the expenditure redirected into other steps of the model (SASIB, 2007). It was proposed that in doing so there would

be more focus on and an increased success of early intervention services, and accordingly the prevention of unnecessary acute admission (SASIB, 2007). As shown in Figure Three, South Australia successfully invested in the development of both the intermediate and secure care sectors, and moved closer to reaching the recommended targets in the other steps of the model. Despite the South Australian beds on average per 100,000 decreasing to 21, KMPG reported an increase in the number of acute bed places in their review of consumer flow across South Australia’s mental health system (2015). Notably, an additional 21 acute beds, at a cost of approximately \$3 million, were also announced in October 2015 (Snelling, 2015b).

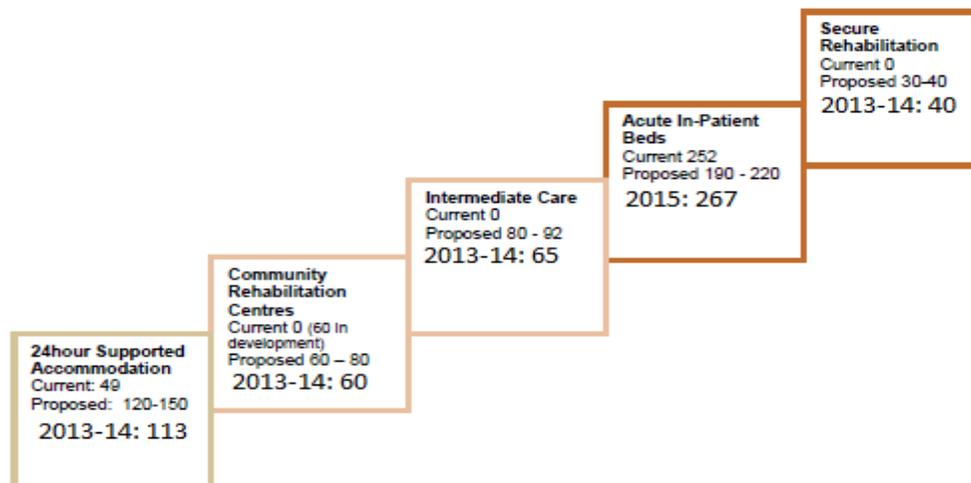


Figure 3. Source: Annual Report of the Chief Psychiatrist of South Australia 2013–2014; KPMG Review of Consumer Flow Across the Mental Health Stepped System of Care, 2015; Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007–2012, p.32.

The report also advocated that community mental health, that is, the non-hospital government services and teams, should act as the ‘cog’ both driving and joining the various levels and sites of support, managing partnerships, and supporting service continuity between primary care, clinical services, psychosocial services,

government services and the community-managed sector (SASIB, 2007). Furthermore, the community-based sector should be responsible for administering and providing all care facilities outlined in the model, except long-term secure and acute inpatient options (SASIB, 2007). Other recommendations that were implemented from this report, which reflected national and international trends, included a more person-centred system focused on early intervention and prevention, the development of an effective, stable, and culturally appropriate mental health workforce, and a renewed focus on encouraging service partnerships within the mental health sector and engagement with cross-sector integrated service provision (SASIB, 2007).

The recent KPMG evaluation noted that, despite ongoing efforts to facilitate a connected, stepped system, disjuncture is still occurring between community mental health services and inpatient teams (KPMG, 2015). This was most evident in the length of stay in emergency departments and acute inpatient bed use increasing in the 2013–2014 period (KPMG, 2015, p.02). Recommendations to address this included clearer responsibilities for consumer care at all steps of the system, clearer allocation of resources and flexibility in the use of these, a review of the ICC model to engage with a broader cohort of consumers, a mental health leadership group, and further work on improving community-acute linkages and relationships at both the organisation and workforce levels (KPMG, 2015). It must be noted, however, that this evaluation did not consider the role or impact of non-government community mental health services (KPMG, 2015, p.06). Ernst and Young (2013) undertook an evaluation that reviewed the capacity of the South Australian stepped system to respond to emergency demand in the mental health sector and similarly proposed that implementation has been the primary roadblock in the effectiveness of the model (p.02). A ‘clinically risk averse culture’ and an absence of strategies to develop a system that supports clinicians to confidently refer and discharge consumers to community settings were identified to be contributing to higher incidences of acute referral and admission, and a delay in

discharge to community options when appropriate (Ernst & Young, 2013, p.05-06). This evaluation also noted that there was no requirement for an increased number of acute beds in South Australia until an imbalance between acute and non-acute services was addressed and the development of an evidence-based community model of service was operating effectively (Ernst & Young, 2013, p.08-09).

In 2011 HOI more specifically evaluated the Individual Psychosocial Rehabilitation and Support Services (IPRSS) programme, one of the initiatives implemented in response to the Stepping Up Report calling for more engagement with the non-government sector. Recovery-oriented and built on an evidence-based model of care, the programme provided out-of-facility services that assisted consumers to engage in meaningful activities that promoted social connectedness, such as training, employment, the development of independent living skills, and participation in social/community programmes (HOI, 2011, p.09-10). Through supporting people in their transition from a facility-based mental health service to community living via partnerships with the community managed sector and government community mental health services, the programme has demonstrated positive outcomes (HOI, 2011). The rates of mental health related hospital admission and length of stay have been significantly affected by the service, with the evaluation finding that admissions were reduced by approximately 39% and the average length of stay by 16% (HOI, 2011, p.06). The evaluation also noted a positive increase in hospital admissions due to non-mental health issues, credited to an increased awareness of physical health needs and access to support in managing these via IPRSS (HOI, 2011, p.06). Not only did these outcomes result in the recommendation for the ongoing implementation of IPRSS, but those who were consulted from the mental health sector strongly agreed that there is an ongoing need for a commitment to the collaborative working relationships between mental health services demonstrated in practice via IPRSS (HOI, 2011, p.04-05).

The Intensive Home Based Support Services programme (IHBSS), a support service aimed at engagement with consumers at a community level, has similarly demonstrated successful outcomes related to the reduction of admissions and length of stay in both emergency and acute inpatient options (Zmudzki, Valentine, Katz, Loebel & Bates, 2015). The programme was funded via an allocation of Commonwealth money linked to the 2010 National Partnership Agreement on Improving Public Hospital Services. South Australia initially established IHBSS with a commitment of \$19.2 million over four years. However, this was revised to \$15.02 million for the period of June 2013 to June 2015 (Zmudzki, Valentine, Katz, Loebel & Bates, 2015, p.05-06). The programme was targeted at people with a severe mental illness and complex interconnected needs residing in suitable accommodation, recently discharged from an acute service (Zmudzki, Valentine, Katz, Loebel & Bates, 2015, p.07). Via a time limited package of support, the programme aimed to improve the mental health and quality of life of the targeted consumers by helping to maintain stable housing and income, develop independent living skills, and engage in community activities to enhance social inclusion (Zmudzki, Valentine, Katz, Loebel & Bates, 2015, p.07). An evaluation undertaken in 2015 found that there was an average reduction of 10.3 bed days for consumers who had engaged with and exited IHBSS, and over half of the consumers admitted to the programme reported that they believed it had helped them avoid an emergency department presentation and an acute admission (Zmudzki, Valentine, Katz, Loebel & Bates, 2015, p.02-03). In analysing the positive consumer outcomes and cost offsets achieved via reduced and avoided acute service usage, the evaluation proposed that IHBSS was reaching a cost neutral position and would function as a highly cost effective community-based option if maintained (Zmudzki, Valentine, Katz, Loebel & Bates, 2015, p.04). Despite the demonstrated numerous benefits for both consumers and cost effectiveness to the sector, the programme was not continued when

initial funding ceased in June 2015 (Mental Health Coalition of South Australia, 2015).

It is evident that South Australia has continued to engage with international and national best practice approaches that are built from a person-centred, recovery model. Additionally, there is significant evidence that a system with strong community based mental health supports and collaborative, integrated service provision contributes positively to an individual's recovery journey and operates more cost effectively. However, notable fragmentation is still evident in the implementation of South Australia's stepped mental health care model, and this has been highlighted as a priority area in the recent establishment of a Mental Health Commission to review the sector and provide recommendations for the development of the State's next five year plan (Snelling, 2015a).

Homelessness and mental health

Mental illness is a cross-sector problem, connected to issues such as employment, housing, education, and social exclusion (COAG) 2012; NMHP, 2008; WHO, 2014). The integration of mental health support across non-mental health community services has been argued as being a vital link in improving the outcomes for those experiencing mental illness (England & Lester, 2005). The NMHP (2008) positions this as a key reform priority in Australia, outlining that there is 'a need to develop ways of fostering partnerships and improving linkages between services provided within and across the primary care sector, the public and private specialist mental health sectors, the non-government mental health sector, and other sectors outside health' (p.19) to more effectively cater to service users with mental health issues. The policy has continued to expand partnerships between clinical providers and community workers, and facilitated the

development of partnerships between sectors such as housing, employment, education, corrective services, and alcohol and drug services.

Those identified as being part of the most vulnerable groups in society are noted to experience mental illness at a higher rate than the broader population. These populations often have a range of complex needs that mental health services alone are unable to resolve, including concerns with stable, safe, and affordable accommodation (Costello, Thomson, & Jones, 2013; Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), 2008; Shaw, 2004). The symbiotic relationship between mental illness and homelessness is well documented, yet the extent of the impact they have on each other is uncertain. The overall health, and more specifically the mental health, of those who are homeless or residing in inappropriate/insecure housing has been shown to be significantly impacted by the experience of homelessness. However, it has also been noted that experiencing a mental health issue can also negatively impact on a person's ability to maintain secure housing (Costello, Thomson, & Jones, 2013; Shaw, 2004). This was highlighted in community consultations and submissions to the Australian Government's white paper on homelessness in which mental health was reported as a significant concern (FaHCSIA, 2008).

Homelessness in Australia has been divided into three categories (Chamberlain & Mackenzie, 1992, 2006; Zufferey, 2008, 2011). People who are living on the street and in public spaces such as parks, or squatting in disused premises are said to be experiencing primary homeless (Chamberlain & Mackenzie, 1992, 2006; Zufferey, 2008, 2011). Secondary homelessness is experienced by those who 'couch surf' or move between short-term non-permanent accommodation (such as with family or friends) and those who are residing in homeless accommodation services (Chamberlain & Mackenzie, 1992, 2006; Zufferey, 2008, 2011). Those with access to medium to long-term accommodation, living in boarding houses or other shared facilities, and those with inappropriate housing

or insecure tenancies are said to be in the tertiary homelessness category (Chamberlain & Mackenzie, 1992, 2006; Zufferey, 2008, 2011). The ABS report, 'Counting the Homeless', estimated that in 2004 there were 104 676 people who fit into one of the categories of homelessness in Australia, and proposed that, in undertaking planning, it would be reasonable to assume that this number would remain stable for the foreseeable future (Chamberlain & McKenzie, 2006). Collecting accurate estimates of how many people experiencing homelessness are concurrently experiencing mental illness is challenging. The final COAG Annual Progress Report of the National Action Plan for Mental Health 2006–2011 estimated that up to 75% of people over the age of 18 experiencing homelessness may be affected by some level of mental illness, and around a third are estimated to be experiencing severe mental health issue (2013, p.07). Although evidence suggests that those experiencing homelessness have higher rates of mental illness experiences (Battams & Baum, 2010; Flatau et. al., 2010), this has been contested. For example, Johnson and Chamberlain (2009) propose evidence that the prevalence ranges from 72% through to 82%, and cite that other studies have reported prevalence as low as between 12% and 44%. A study by Johnson and Chamberlain (2009) reviewed 4 300 case histories of those experiencing homelessness, and found that only 31% identified with experiencing mental illness. Half this number reported that they were already experiencing mental illness prior to losing secure accommodation. Notably, the rest stated their experiences of a mental illness occurred after becoming homeless (Johnson & Chamberlain, 2009).

Until 2011, Australia's primary programme for those experiencing homelessness was the Supported Accommodation Assistance Program (SAAP). This programme provided crisis accommodation and support services to people who were homeless or at high risk of becoming homeless, and was funded jointly from Federal and State budgets. Data collected through this programme in 2011–2012 found that 19% of those who utilised the service were experiencing a mental

health issue (AIHW, 2012). In 2011, this programme was transitioned to become the Specialist Homelessness Services (SHS). Data from this programme suggested that in 2013–2014, 22% of the people seen experiencing or at risk of homelessness were also a consumer with a current mental health issue, and 44% of these people reported that they had experienced an episode of homelessness in the previous 12 months (AIHW, 2014). Notably, only 29% of consumers in the programme who were not identified as experiencing a mental illness had experienced an episode of homelessness in the previous 12 months (AIHW, 2014). To be classed as having a mental health issue these people had to meet one of the following criteria:

- they indicated that at the beginning of a support period they were receiving services or assistance for their mental health issues or had in the last 12 months
- their formal referral source to the specialist homelessness agency was a mental health service
- they reported 'mental health issues' as a reason for seeking assistance
- their dwelling type either a week before presenting to an agency, or when presenting to an agency, was a psychiatric hospital or unit
- they had been in a psychiatric hospital or unit in the last 12 months
- at some stage during their support period, a need was identified for psychological services, psychiatric services or mental health services (AIHW, 2014, p.01).

In 2014–2015, one in four (25%) SHS consumers were identified as having a current mental health issue (AIHW, 2015). Of those, over half stated they were in need of support from mental health services, and when compared to those who used the SHS who did not identify as experiencing mental illness, they were also more likely to need a drug or alcohol service and other medical services

(AIHW,2015). Forty-nine percent identified as requiring support for material/resource support, 38% required finance management information or assistance, and 34% stated that they needed help with transport (AIHW, 2015). These statistics demonstrate the complex and interrelated issues that those experiencing a mental illness face, and it has been noted that these clients often require support services longer than other SHS users (AIHW, 2015). People with a current mental health issue have been identified as the fastest growing client population for the SHS, with an estimated average increase of 12% annually (AIHW, 2015). SHS have reported that many people seek out the service following discharge from a hospital, but that this is even more prevalent for those whose admission to hospital or acute care was for a mental health-related concern (AIHW, 2015; Costello, Thomson, & Jones, 2013). For many of these people, the need for SHS support has been attributed to a lack of accommodation before admission, or discharge to short-term or unstable accommodation (such as with family or friends) (Costello, Thomson, & Jones, 2013). It has been argued that the deinstitutionalisation of mental health services and subsequent insufficient redirection of resources to community services from this has resulted in those experiencing mental illness having poor access to housing and housing supports, and as such experiencing higher levels of homelessness (Costello, Thomson, & Jones, 2013; Dear & Wolch, 1987; Forchuk et. al., 2007; Fulcher, 1989; Groom, Hickie, & Davenport, 2003; Robinson, 2003).

There is strong evidence to suggest that there is a need to not only make available affordable and secure housing for those experiencing mental illness, but for an approach that integrates these with services to engage more holistically to address complex and interrelated needs in a cross sector, coordinated way (Battams & Baum, 2010; Costello, Thomson, & Jones, 2013; O'Brien, Inglis, Herbert, & Reynolds, 2002; MHCA, 2009; Penrose-Wall & Bateman, 2006; Rosenheck & Morrissey, 1998; Thomas & McCormack, 1999). An American study undertaken by Gilmer, Stefancic, Ettner, Manning, and Tsemberis (2010)

highlighted that consumers who engaged with a fully supported partnership service, providing an integrated model of subsidised, stable accommodation, and clinical and psychosocial support services, reduced both the mean number of days spent homeless and the likelihood of requiring acute or emergency services. Additionally, these consumers also reported a greater quality of life (Gilmer et. al., 2010). More locally, Lee and colleagues (2010) evaluated an integrated programme in Melbourne, and found that engaging mental health staff within two welfare-focused agencies not only improved inter-service collaboration, but the continuous service and case management facilitated consumers achieving greater stability in their accommodation. They were also more likely to only require secondary support of the psychiatric service provider involved with the programme (Lee et. al., 2010). Research by Spicer, Smith, Flatau, and Burns (2015) similarly demonstrated that an integrated approach, providing supported medium to short-term accommodation, resulted in better accommodation outcomes for men experiencing mental health issues and homelessness in Sydney. However, it must be noted that they were unable to ascertain the effect on individuals' mental wellness. Goldman, Morrissey, Rosenheck, Coccozza, Blasinsky, and Randolph (2002) noted a similar finding in their evaluation of ACCESS, an integrated programme in America, summarising that people engaged with the programme were more likely to achieve stable accommodation, but the impact on measurable mental health outcomes was not significantly more than those achieved with good clinical service. Other research by Reynolds and Inglis (2001) found that services that incorporated housing, clinical, and community support positively contributed to the recovery journey for those experiencing mental health problems, with stable housing improving mental health and wellbeing.

It has been found that those living with mental illness who are able to remain in accommodation via integrated support mechanisms are less likely to re-enter or experience homelessness, and that when integrated community accommodation

options are compared to institutional or facility-based care, they generally demonstrate more effective outcomes (Carter, burke & Moore, 2008; Mansell, 2005; MHCA, 2009; Rosenheck & Morrissey, 1998). However, research has also demonstrated the value of good quality acute, institutionalised or facility-based care for certain consumers and notes that these services still play a vital role in the sector (Mansell, 2005). The outcomes for either model have been argued to be dependent on service structure, integrated social supports, quality, and appropriateness to consumers, rather than service type (Costello, Thomson, & Jones, 2013; Mansell, 2005, p.22). This was highlighted by Kuno, Rothbard, Averyt, and Culhane (2000) who found that an 'enhanced community-based mental health system was not sufficient to prevent homelessness among high-risk persons with serious mental illness' (p.1012). Kuno et al. did note, however, that a strong community sector with continuous, integrated provision will more effectively contribute to positive recovery outcomes.

The need for and benefits of a more integrated approach for those concurrently experiencing mental health and housing issues have been recognised in Australia (Costello, Thomson, & Jones, 2013) with the Federal Government's white paper on homelessness, 'The Road Home', stating that 'the failure to provide more of these integrated services for people with mental illness significantly impedes their ability to achieve better social and economic outcomes' (2008, p.31). Notably, the National Partnership on Homelessness 2015–2017 outlines that any new or expanded services developed to assist those experiencing mental health issues should be done so in partnership with the government and NGO sector and feature not only housing support, but a range of holistic services, including clinical and community-based options to enhance an individual's recovery journey and ability to participate in their community.

Several programmes have been developed to support the implementation of the National Mental Health strategy objectives and the National Partnership on

Homelessness objectives related to a more consumer-centred, recovery-orientated, collaborative, and integrated mental health system. The Partners in Recovery (PIR) programme is a notable example as its primary function is to implement changes that will improve the collaboration and coordination between clinical and community services (Costello, Thomson, & Jones, 2013; Department of Health, 2015). The programme is aimed at people identified as experiencing a 'severe and persistent mental illness with complex support needs' who may be disconnected from social support networks, experiencing co-morbid health/social welfare issues such as substance abuse or homelessness, and reliant on multiple services and agencies to assist them with a range of supports (Department of Health, 2015). Consumers engaged with PIR are assigned a facilitator through a locally accessible non-government PIR organisation which works in collaboration with the individual, key people in their life, and their various service providers to develop and coordinate an action plan that supports the consumer's recovery journey goals (Costello, Thomson, & Jones, 2013).

Personal Helpers and Mentors (PHaMs) is a federally funded mental health programme notable for its recovery-oriented, strengths-based approach as well as a focus on person-centred support that connects with correlated social welfare agencies, including accommodation and drug and alcohol services (Department of Social Services, 2014). Reflecting trends in a range of mental health services, the number of people participating in the programme increased by an annual average rate of 17% from 2009/2010 to 2013/2014 (AIWH, 2014). Notably, the PhAMS programme has been funded as part of the Government's response to homelessness, and as such also works with those experiencing mental illness to secure accommodation and link them to SHS services if required (FaHCSIA, 2008). Furthermore PhAMS supports consumers with interconnected issues such as low income, limited living skills, or difficult behaviours that affect a consumer's ability to maintain accommodation (FaHCSIA, 2008). In addition to this collaborative approach, PhAMS also draws on the documented benefit of peer

workers, with the programme having a number of facilitators with lived experience (Courage Partners, 2011; Department of Social Services, 2014). The programme has continued to be supported by the sector as a positive service option for those experiencing mental illness. An evaluation of the programme undertaken for the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs reported those who had received PHaMs service were positive about the programme and that, overall, clients reported a service that was empowering, recovery-focused, and effective (Courage Partners, 2011).

The Housing and Accommodation Support Initiative (HASI) in New South Wales has been noted by several sources as a model that has demonstrated success in integrating mental health and broader social supports to gain and maintain accommodation for those experiencing mental illness (Bruce, McDermott, Ramia, Bullen, and Fisher, 2012; Muir, Fisher, Dadich, Abelló, and Bleasdale, 2007). The programme operates via partnership between NSW Health, Housing NSW, and the non-government sector to support consumers with their accommodation, clinical, and psychosocial needs. Clients are provided with accommodation, tenancy support, clinical care, and rehabilitation and personal support (Bruce et. al., 2012; Muir et. al., 2007). The service provides two levels of support. It provides a high level of support to those with severe and high levels of psychiatric disability who are at risk of homelessness, who reside in insecure or inappropriate housing, or who are currently homeless. The service provides a lower level of support to those consumers who have stable housing but who are at risk of losing their tenancy unless they gain support from an integrated range of services. The collaborative, cross-sector approach of this programme has demonstrated measurable success in helping mental health consumers to transition out of homelessness and maintain accommodation (Muir et. al., 2007). HASI has also been evaluated as a cost effective option in comparison to other service options supporting adults concurrently experiencing mental health and accommodation concerns (Muir et. al., 2007). A 2007 evaluation highlighted that 70% of HASI

users were able to maintain their accommodation for 12 months or more, and reported improved socioeconomic factors (Muir et. al., 2007, p.06). Additionally, 84% of HASI users experienced reduced admissions and time spent in acute care and emergency departments (Muir et. al., 2007, pp.10-11). A more recent evaluation highlighted that the programme has continued to produce and increase successful outcomes with 90% of HASI users maintaining their tenancy (Bruce et. al., 2012, p.105). Consumers engaged with the programme reported reduced time spent in acute services, a sense of improved mental health, and feelings of independence and community engagement (Bruce et. al., 2012, p.13-14). The 2012 evaluation noted the success of HASI partnerships being attributable to four factors, all of which have been identified as core concepts of integrated, collaborative practice approaches: clear roles and responsibilities, open communication, commitment to working together, and sound governance processes (Bruce et. al., 2012, p. 22). Although these partnerships linking accommodation, clinical and psychosocial services were deemed to have been implemented well and as having demonstrated positive impacts for consumers, Bruce and colleagues noted the programme was hindered by waiting lists for housing, which impacted client flow through the programme and the service partners' ability to provide a coherent service (2012, p. 173).

The South Australian Housing and Accommodation Support Partnership (HASP) programme utilises a similar integrated service model to HASI, based on collaborative partnerships between consumers, carers, NGO housing providers, psychosocial support providers and community mental health services (HASP Guidelines, 2010). The programme is aimed at those experiencing severe mental illness who meet the following criteria:

- have non-existent, lost or limited independent living skills
- are eligible for housing with the housing provider
- have an identified mental health contact person
- are homeless or at risk of homelessness, which includes being housed in inadequate, unsustainable or inappropriate housing (HASP Guidelines, 2010, p.12).

The service offers moderate to high intensity support and is underpinned by a recovery-oriented approach with the aim of improving living skills and social connectedness, assisting in obtaining and maintaining tenancies, strengthening community and personal networks, and helping consumers transition from facility-based accommodation and service options to independent or supported community living (HASP Guidelines, 2010). Like HASI, the collaborative integrated approach of HASP has been evaluated as effective, resulting in positive outcomes for consumers and contributing to reduced pressure on the hospital system. Most notably, the programme has seen a 64% reduction in the use of inpatient facilities, and a 42% decrease in the length of stays for those participating in the service (HOI, 2013b, p.71). The presentation of these consumers at emergency departments has also decreased (HOI, 2013b, p.71). Thirty-one percent of those engaged with the service experienced improved wellness indicators (HOI, 2013b, p.74). Both consumers and carers reported improved mental health, social engagement and capacity in living skills that helped maintain stable and appropriate accommodation (HOI, 2013b, p.74). Community mental health services, NGOs, and housing providers engaged in the programme also reported success with the model, advocating for the further development of a defined partnerships framework and clearer roles to improve communication and ensure continuous, coordinated service responses for consumers (HOI, 2013b).

Summary

This research aims to explore not only the reform priorities for South Australia as identified by key stakeholders, consumers and carers, but to examine the sector's experience of integrated, collaborative service approaches, such as those highlighted in this literature review. A specific focus on accommodation and mental health services underpins this study, but it must be noted that this research engages with a holistic person-centred approach to mental health in which consumer's mental health needs are seen as cross-sectoral and connected to a range of biological, psychological, and social factors. Previous research has demonstrated the positive impacts of a stepped system of mental health service, in which community-based options operating from a recovery, person-centred framework ensure early intervention and reduced pressures on acute services. However, no study was located that synthesised the experiences of South Australian stakeholders, consumers and carers after the implementation of a stepped model of care. As such, this qualitative study aims to provide a mechanism through which the voices of those developing policies, implementing service provision, and utilising services can inform future reform both locally and nationally.

Research method

This project aims to explore the community mental health and related community sector priorities for mental health reform in South Australia with particular focus on identifying barriers to the provision of cross-sectoral service integration for service users experiencing mental illness. It further aims to explore the value of sustainable accommodation combined with appropriate support in the recovery journey for people living with mental illness. Underpinned by a qualitative methodology to reflect the project's aim of exploring situational, context-based perspectives and experiences of the South Australian mental health sector

(Neuman, 2000; Sarantakos, 1998), data was collected in three stages. Stage one, informed by the research question 'What are the community mental health and related community sector priorities for mental health reform?', involved a targeted literature review to establish current significant and emergent concepts, and the South Australian mental health service context. It subsequently involved 12 qualitative interviews with key stakeholders in mental health policy and service delivery. Stage two, informed by the research question 'To what extent does sustainable and high quality accommodation combined with appropriate supports contribute to the recovery journey?', involved 12 qualitative interviews with key stakeholders exploring how integrated accommodation and cross-sectoral supports may contribute to enhancing the recovery journey for those experiencing mental illness. The interviews also explored barriers to the implementation of such systems of service delivery. Potential participants for stage one and two were approached via purposive and snowball sampling (Neuman, 2000; Punch, 1998; Sarantakos, 1998).

Stakeholders in mental health policy and service delivery from both the government and non-government sectors were identified by the research team and initially contacted via email inviting them to participate. Potential participants were also informed they could voluntarily pass on the study information to others who would be interested in contributing to the project. Interviews in these stages were qualitative and conducted using a one-to-one semi-structured approach. Each interview took between 30 and 60 minutes and was held at a location which ensured confidentiality and was most convenient to participants. Issues explored in the interview prompts included views on what the community mental health sector and the other broad community social services that engage with those experiencing mental health issues looks like in South Australia; proposed mental health reforms and ideas for achieving these in the practice context; the barriers to cross-sector integration; and the outcomes of combining accommodation and

support services for those experiencing mental health issues. All interviews were audio recorded and handwritten notes were taken for review during data analysis.

Stage three explored consumer and carer priorities for mental health and associated housing reform and was underpinned by both research questions. Data collection was undertaken via two focus groups. The first group consisted of eight consumers engaged with a mental health service, and the second group consisted of seven carers of people engaged with a mental health service. Potential participants for these groups were contacted via purposive and snowball sampling (Neuman, 2000; Punch, 1998; Sarantakos, 1998) through community mental health agencies located within the Mental Health Coalition of South Australia network. Service providers at these agencies were contacted via email and asked to inform their clients of the study and provide the information sheet and consent form from which they could self-select to participate by making contact with the research team. Focus groups were conducted at a centrally located partner agency of the Mental Health Coalition of South Australia and participants were compensated for their time and travel. Both groups discussed priorities for mental health and associated housing reform, drawing on the themes identified in stages one and two of the project.

The data gathered was analysed using thematic analysis as described by Braun and Clarke (2006). The first step in this process involved reviewing the audio recordings and the handwritten notes taken during the interviews. Coding was undertaken manually and involved the identification of interesting or similar extracts, repeated patterns and accounts that resisted or contradicted dominant narratives. These codes were analysed and grouped into themes which were compared and contrasted to known themes within the body of existing literature identified in this area. During this transcription process all participants' and any identifying data (such as agency names) was allocated a pseudonym to ensure confidentiality.

Data analysis also involved a collaborative roundtable process which allowed participants, project partners and other key stakeholders in the sector to review and provide feedback on the initial draft of the themes and recommendations developed from the findings of the research. Two roundtables were held – one for consumers and carers, and one for sector stakeholders. Recommendations were presented via PowerPoint and group discussions were facilitated to explore these in depth and allow for participants to collaboratively contribute to the final analysis via an in depth conversation with the researchers. Notes were taken and groups were provided paper to record their feedback, which was then thematically analysed and incorporated into the final recommendations.

Findings and discussion

The themes from this project were not unexpected and in essence reflected documented concerns in the mental health sector nationally. This is significant in that it suggests a strong narrative exists across the mental health sector about the necessary reforms in South Australia. It is notable that all participants in this study described feeling frustrated that the themes discussed continue to be hurdles in delivering a connected, person-centred and recovery-oriented system. This report has aggregated these conversations, identifying five key themes and providing a set of recommendations that reflect the desired reform priorities identified in the stories of those who participated in the project. The roundtable discussions, in which participants and sector stakeholders could provide feedback on the recommendations, not only reiterated these themes, but also clearly demonstrated the sector's desire to develop an evidence-based, collaborative approach to policy and practice.

Key theme one: Stepping up – a system unbalanced

The concept of a community-driven, graduated level system developed in the Stepping Up Report was strongly supported and commended for its role in policy reform by those interviewed in this project. Research participants advocated for a system in which people experiencing mental illness could access services focused on early intervention and prevention, and one that was structured so that ‘any door is the right door’ for entry into support. All participants noted the need for a stronger focus on community services in South Australia, with a majority agreeing the community-managed sector should have its role expanded. This was linked to a belief that acute support services should be a resource for the community-based sector to draw on, and refer to when needed, rather than an initial or only point of entry into support programmes. It is notable that there was a significant amount of goodwill towards the initiatives proposed in the Stepping Up Report, including the subacute level of ICC and CRC. It was also clear that participants believed the report to be outdated and that, although an initial investment into infrastructure had been made, the implementation of wrap around policies had not occurred nor was funding provided to support these. The shortcomings of the current model were attributed to this poor implementation of proposed services and processes rather than an ill-conceived reform agenda. This reflects the findings of the NMHC’s (2014) report, which advocated for the implementation of a stepped care model but identified a fragmented, ad hoc system nationally.

A dominant clinical narrative sub-theme emerged in participant responses as the core barrier to the successful implementation of the reforms proposed in the Stepping Up Report. This was referred to significantly throughout the interviews and participants believed it to be evident in the increasing focus on acute bed numbers within the mental health sector. It was evident in the participants’

accounts that despite policy that positions South Australia's mental health system as being built on an early intervention and prevention, community-based model as outlined by WHO (2007), in practice the priority for allocated funding, power and influence is heavily weighted in favour of clinical and acute-based services.

Concerns for the influence and power wielded by medical associations and psychiatrists within the system was raised, with this being seen as the main roadblock in achieving a mental health sector built on community-oriented services. The increasing shift in focus to acute bed numbers was described as being fundamentally a political one, and participants suggested that beds are used as a tool to garner public support and that Government is hesitant to commit to substantial reform in a sector that is 'not sexy'. Participants stated that mental illness was still highly stigmatised and misunderstood in the general community, and is often overshadowed by other social welfare issues.

Sector Stakeholder: If we are faced with a problem people naturally want to see how it can be solved, so when they hear mental illness, for people that don't understand, or have contact with mental health services the very easy conclusion or solution can be mental illness has the word illness, where do people go when they are ill? A hospital. So give them a bed and the problem will be solved.

Several participants also described negative impacts on consumers associated with being positioned in a medically focused 'patient' role, including disempowerment and a focus on clinical symptom management rather than personal recovery. Three participants noted that a clinical lens on consumer care may also foster service dependency, in which those experiencing mental health issues become unduly reliant on acute, clinical interventions. This can be said to indicate the need for increased community-based service options, but also more engagement with, and support for, the natural communities that surround a consumer, which one participant described as follows:

Sector Stakeholder: Community in a broader sense, the unpaid supports, family, friends, employers...the client's whole community.

The value of engaging with this network of people is widely documented, and a focus on building resilience via natural communities may prove an effective tool in fostering the concept of a 'contributing life' as proposed by the Mental Health Commission of Australia (2014).

Supported accommodation: The steepest steps

The effectiveness of a system so heavily focused on acute care was questioned, with the majority of participants arguing acute beds are inefficient and a symptom of a system unable to support clients before they reach levels of severe ill health or crisis. All stakeholder participants (from both acute and community backgrounds) acknowledged an urgent need to refocus on community-based support to rebalance the system, whilst consumers wanted to be able to stay out of hospital and have increased access to and knowledge of community based options.

Sector Stakeholder: If you invest in community services you will dramatically reduce the need for people to see acute services, which is the expensive end of service delivery, and you'll see an incredible increase in the person's sense of health and wellbeing.

A cycle of entry into the system was highlighted in participant accounts. The cycle was said to be triggered when consumers faced difficulty in accessing support at early signs of mental illness and in engaging with broader social welfare supports that contribute to their ability to remain well (such as accommodation, counselling, income support, etc.). This results in crisis, and the consumer presents at an emergency department where they are either given an acute bed or discharged

upon treatment with medication. This 'fly in fly out' dimension of acute and emergency departments was said to result in social exclusion, with sporadic episodes of acute, facility-based care said to contribute to the breakdown of relationships and impact the ability of consumers to sustain needs such as income and housing. Support on discharge from an emergency department or from an acute bed was described as 'non-existent', and the lack of linkages to services when transitioning to community was noted as a disservice to consumers. This was linked to concerns about consumers' ability to step between levels of supported accommodation, and a lack of housing stock or options was noted as the primary barrier to an effective flow through in the system. It was acknowledged that although a lack of housing stock is not a unique experience to consumers of mental health services, they experience far more barriers in securing suitable accommodation.

Sector Stakeholder: Mental health consumers do not get a gold pass to anything, when they should be front of the queues for housing, income, education and employment supports.

Concerns were raised about the ICCs not operating as intended. Due to clients becoming stuck in subacute beds, they were not functioning as short-term or bridging options. The current ICC model was recognised as ineffective. However, it was strongly proposed that reform of how the ICCs are managed was necessary rather than the closure of subacute beds in exchange for acute places.

Sector Stakeholder: We didn't roll them out in the best way, but we shouldn't throw them out either.

Notably, participants identified a lack of integrated or collaborative partnerships, in addition to the facilities being run by the clinical sector as the primary problems with the ICC model. An alternative was proposed, in which ICC-style facilities are

contracted to a NGO and centred on community-based psychosocial support with intensive clinical support in-reach, with a suggestion that it would reduce reoccurring 'stepping up' from subacute to acute care.

Sector Stakeholder: Why did we have it clinically led? Why didn't we just let the NGOs do it?

Additionally it was noted that even if ICCs were a more community-based service, people would still be unable to transition out of the service due to a lack of capacity in less intensive supported options.

Sector Stakeholder: They are being used as an overflow from acute.

This again reflects a strong narrative within this research, and the broader literature, that reinvestment into community-based mental health services must be considered. There was no significant consensus about a model of accommodation that would work most effectively to provide consumers with ongoing support when moving out of subacute facilities. The HASP programme and CRCs were applauded for filling this gap to some degree: both programmes operate on a collaborative, community driven model, with partnerships between NGOs, community housing providers and government community mental health teams providing integrated psychosocial and clinical support. Evaluation of HASP and IHBSS reflect the views of those interviewed, and highlight the potential benefit for both consumer outcomes and cost effectiveness in fostering a system based on integrated, collaborative and community driven models. It must be noted that the limited availability and waiting lists for these options was a concern for mental health sector stakeholders. Despite positive views on the programmes, it was evident they are under pressure and unable to meet current consumer demand and need. Participants noted that the barriers to maintaining or expanding these programmes to better support those experiencing mental illness

included funding, workforce culture and the influence of dominant clinical discourse, all of which were reoccurring themes in this research.

Consumer and carer responses reflected concern about the availability of community-based supported accommodation, communicating frustration with accessibility as well as with the suitability of the accommodation available.

Consumer: Sometimes it's better to get sick so you have somewhere to go.

This sentiment of a system filled with roadblocks reflected concerns of several interview participants who felt the system is set up to respond to crisis and to act as a gate keeping mechanism on demand.

Sector Stakeholder: We are counter intuitive: we wait for people to become unwell before offering assistance.

Risk averse 'experts': A system blockage

Difficulty in accessing supported accommodation was in part attributed to a system which requires referral to be undertaken via a government community mental health service, and as such via an acute crisis episode.

Sector Stakeholder: We have our admissions here go through EDs, which is an absolute debacle, it's a shocking system for everyone involved.

Those interviewed proposed reforming how these services can be accessed, describing a person first system in which primary health services such as GPs, other social welfare services (employment, housing, etc.) in both NGO and Government sectors, carers and consumers themselves could refer based on identified need. Participants also identified a perception of an ill equipped non-

government sector acting as a barrier, with one participant stating NGOs were seen as the 'poorer cousin'. This emerged as a recurring theme when discussing the redistribution of resources into the community managed mental health sector and, notably, was highlighted by stakeholders from both non-government and government backgrounds. Several participants stated that staff in government operated community mental health services are hesitant to discharge people from more intensive support options or accommodation due to a perception that the community managed mental health sector is unable to maintain consumers' levels of wellness. This is consistent with the findings of Carter, Burke and Moore (2008) who examined the effectiveness of the discharge, accommodation and support of consumers from Glenside psychiatric hospital through the programme Returning Home. As stated in their report, 'a number of respondents expressed misgivings about the way the non-government agencies funded under Returning Home approach their work. They described agency workers as 'semi-trained' or untrained, and held that they should be supervised by, and act at the direction of, clinical staff' (Carter, Burke & Moore, 2008, p.45). Participants in this research challenged this perception, citing IHBSS, IPRSS and CRCs as examples of effective and professional services led and managed by a highly capable community-managed sector. It was also highlighted that many of the staff within the community-managed sector are now equally or higher qualified than those working within community mental health teams. Additionally, it was proposed that they might be better placed to recognise early signs of mental ill health in their community-based interactions with consumers.

Sector Stakeholder: The mental health sector is quite risk averse and they don't trust the NGO sector, they don't trust the NGOs are going to do a good job. The NGO sectors could do more, but the community mental health services don't want them to because they don't think they can do it.

The term 'risk averse' was used to describe a culture in which clients were maintained in services that are potentially inappropriate for the level of support required. It was suggested that this was underpinned by a clinically focused mental health sector in which 'health professionals (psychiatrists, doctors, nurses) are seen as the "experts."' Again, this reflects Carter, Burkes and Moore's findings: 'in South Australia the provision of care and treatment promoting rehabilitation for users of mental health services had been regarded as the province of clinical providers' (2008, p.62). It could be argued that this recognised risk averse culture not only contributes to blockages in the stepped model of care, but may also negatively impact on consumers, marginalising their voices and needs. This risk averse approach, along with medical/expert knowledge discourse, was noted in the consumer and carer focus groups. This suggests that the mental health sector is yet to truly engage with person-centred practice, in which the consumer is the expert of their experience, and service delivery and supports are driven by the person's unique, individual recovery goals and needs.

Consumer: You have things done to you, and people talk about you rather than to you.

Recommendation 1: Refocus on the effective implementation of a stepped system of care, rebalancing roles and resources within the mental health sector to best serve consumers at their level of need.

To implement this recommendation it is suggested that:

- the system be refocused on early intervention, prevention and community based supports through the development of a strategic long-term plan to increase collaboration and integration within the South Australian mental health sector;

- emphasis be placed on effective implementation of a graduated stepped model, and particularly on community-based and subacute options such as ICCs, crisis respite, and intensive home based support;
- the acute and community-managed mental health sectors continue to improve their collaborative partnerships;
- reform places consumer recovery goals and needs at the core of the sector and focuses on offering people access to the support they need when they need it via a flexible, open door system that allows entry and exit at various steps, rather than via an acute episode.

Key theme two: Strategy and reform – connecting the parts

Participants in both the individual interviews and focus groups noted a lack of an overall strategic direction in mental health in South Australia. They hoped the South Australian Mental Health Commission would have the power and independence to both direct and link together policies, strategies and funding to facilitate a more connected, flexible and responsive system. It must be highlighted that the perceived fragmentation and stagnation within South Australia was linked to a lack of focus on mental health since the Stepping Up Report came to the end of its lifespan in 2005, as well as an outdated Mental Health Strategy. Furthermore, the impact of a lack of cohesion between State and Federal funding and policies was identified as a concern for participants. This was underpinned by a fear that a lack of forethought to ensure local reform 'jigsaws' with federal reforms (most notably the NDIS and the response to the Mental Health Commission's Review of Programmes and Services) could result in consumers falling through gaps or experiencing ineffective and potentially harmful services provision.

When asked about their perceptions of the NDIS, a majority of participants believed the move towards a consumer directed model of care was a positive one. Reflecting the current research literature, a commitment to allowing consumers more control and flexibility was highly regarded. Interviewees noted that the NDIS will not accommodate all mental health consumers, and although many understood the system's 'target population', concerns were raised about those who will not be eligible. The limited packages available to mental health consumers is documented in literature, and this research suggests there is an increasing anxiety within the mental health sector for those with complex mental health needs who will not meet the criteria of being severely or permanently disabled. Reflecting concerns about disconnection between State and Federal reform, it was noted that, currently, it is not clear how psychosocial services for those outside of NDIS will be funded. Participants voiced reservations about the availability of ongoing block funding due to resources being rolled into the NDIS pool and strongly advocated that the welfare of those ineligible for NDIS support must be maintained by the State. There were conflicting views on how the NDIS could affect quality of service in the mental health sector, with some expressing the view that the market place model may push NGOs to work harder at providing services that consumers will want to 'purchase'. In contrast, others suggested that this model might potentially reduce options for clients as smaller organisations may be unable to maintain services and larger organisations may limit their programmes/services as they are forced to decrease costs to remain competitive.

Additionally, staffing and service quality in an NDIS focused sector was described as a 'looming problem' for mental health services, particularly the community-managed mental health sector. Concern was expressed about how current support for a workforce comprised primarily of those with a minimum Certificate IV can be maintained in a market model designed for the disability sector, where Certificate III workers generally fill social support roles. This was intertwined with

a fear of being unable to provide adequate training and supervision under the NDIS model, an inability to retain higher qualified staff and a view that this may in turn result in reduced service or quality options for consumers. It was highlighted that the mental health sector has undertaken significant work in upskilling the workforce and that this work needs to be supported going forward.

It is of interest that when the NDIS reform was raised in the focus groups, consumers felt ill informed about whether they would be eligible and what an NDIS package would look like for them. Carers, in comparison, could be described as sceptical, voicing a view that they did not see it changing the level or quality of service those they cared for would receive. They felt that the information they currently had about the system was unclear and confusing. This suggests that engagement with carers and consumers about the reform, especially in regards to those experiencing or caring for someone with complex, chronic mental ill health, will need to be undertaken to facilitate access to any support they may be entitled to.

Participants also noted the potential impacts of the reforms announced in the Federal Government's response (2015) to the Review of Mental Health Services and Programmes (2014) undertaken by the National Mental Health Commission. Generally, participants were positive about the reform, suggesting it was a sound attempt at addressing issues noted in the National Mental Health Commission's report overall. The online mental health gateway and a renewed focus on the mental wellness of Aboriginal people and youth, as well as further investment in suicide prevention, were well received. The report proposed a stepped model of care with a significantly clearer investment in early intervention/prevention strategies for those experiencing mild to moderate mental health issues, centred on primary health care pathways, and this was considered a positive step in reforming services in Australia. The new funding model in which PHNs will act as commissioning agents for mental health services was the area of most interest

and least clarity for stakeholders. The ability for PHNs to act locally was questioned, with argument that the two PHNs established in South Australia (one for Adelaide and the other for the rest of South Australia) could not adequately address the complex individual needs of consumers. An argument could be mounted, given the vast distance between regional locations in South Australia, that more PHNs could be set up, or a system of sub-branches be developed in order to successfully implement population needs-based services as proposed in the reform.

It was highlighted that the PHNs are not experts in the mental health field and this could potentially prove to be an opportunity or a barrier to improved services. Participants were hopeful that the PHNs would draw on the vast range of expertise from across the mental health sector, both at community and clinical levels, and seek to commission early intervention and prevention-orientated community-based services with clinical supports. However, stakeholders were also wary of the impact that residual clinical influences from the initial manifestation of PHNs – Medicare Locals – could have on hindering this reform. In acting in a commissioning role, it was envisioned the PHNs would fund services on a needs basis, as well as developing a sound understanding of existing services and effective models of support and working with the mental health sector to enhance and expand these. Notably, several participants were not as positive about the commissioning model, suggesting it would end up operating as a competitive tendering process with a new name. It was proposed that the mental health sector needed to decide what 'our job is' and how to best undertake that job to ensure the effectiveness of the commissioning model, and this was closely linked to a view that the development of more appropriate outcome measurements was required.

Recommendation 2: Facilitate an integrated system. This system must be designed to effectively connect federal and state mental health funding and services, including the NDIS and PHN, a well-resourced community-managed sector, consumers and carers.

To implement this recommendation it is suggested that:

- the State Government ensures that the South Australian Mental Health Commission has the independence and authority to seek information and provide recommendations, and has the requisite resources to implement reform;
- the South Australian Mental Health Commission engages a governance structure that places representation from the community and acute mental health sectors alongside representation from consumers and carers;
- the governance structure of the South Australian Mental Health Commission ensures that the voices of all mental health sector stakeholders are equally valued and that their input and expertise is reflected in policy and reform;
- the South Australian Mental Health Commission facilitates the development of a State Charter that articulates a shared vision for integrated, recovery-oriented and consumer-focused reform, endorsed by all interested parties;
- the South Australian Mental Health Commission works with consumers and carers, SA Health, the community-managed sector, the NDIA and the PHNs, to inform, develop and implement an effective mental health

ecosystem in South Australia that engages with broader sector reform and national policy.

Key theme three: Fostering collaboration – integrating a person first approach

One of the strongest themes to emerge in this study was a recommendation for engagement with a more collaborative, integrated system that wraps around consumers. Ensuring that any reforms facilitated a system designed to address the range of 'social health needs' that contribute to an individual's mental wellness was a key priority for those interviewed, which loudly echoes previous research undertaken in this area. Not only were collaborative partnerships viewed as more capable of working with consumers to achieve their recovery goals in a meaningful, holistic way, but they were proposed as the missing piece to link up the various parts of the currently fragmented stepped system of care. Participants saw value in fostering partnerships not only in the mental health sector (government/non-government services, and clinical/psychosocial services), but also across sectors (housing, employment, income support, etc.). This aligns with evidence that a system that utilises respectful and clear communication and shares information and resources based on consumer need results in better outcomes for consumers and more cost effective services. Programmes such as IPRSS and IHBSS were cited as successful examples of this approach, with participants suggesting they help fill the gap between acute beds and independent community living. These programmes were also positioned as being an important part of rebalancing the mental health sector by refocusing services on early intervention and addressing a perceived gap between primary health care contact and acute admissions. It must be noted that many participants expressed disappointment and frustration at the decision to not re-invest in IHBSS and the subsequent cessation of the service. These programmes, and the funding

to encourage other services to operate in similar ways, were seen as needing greater investment and roll out.

Collaboration between accommodation support and mental health services was specifically explored for this research, and it was unanimously agreed that this needed to be ingrained as the standard practice. Consumers and carers shared similar views, describing the disconnect between their housing and psychosocial or clinical supports as a contributing factor to episodes of illness due to anxiety over their accommodation, homelessness and concerns for safety. Several programmes, including the HASP initiative, were highlighted as demonstrating the effectiveness of wrapping psychosocial support around accommodation to assist consumers to maintain tenancy and stay well.

Sector Stakeholder: What was successful about (HASP) was the insistence they were equal partners, that they had equal say.

HASP, developed as part of the Federal Government's response to homelessness, is executed in partnership with a non-government agency, a housing provider and community mental health team, based on an individual's recovery goals and needs. It is a model that has seen success in various forms around Australia. It can be surmised that the strong support of such approaches in not only this study, but in programme evaluations and previous research, is indicative of its success in addressing the broader needs of mental health consumers. As such, reforms in South Australia must engage with fostering collaboration within the field.

This study identified several barriers to the implementation of collaborative partnerships in South Australia, most of which hinged on resources and funding. All participants noted that social welfare services broadly, including in mental health, had to do 'more work with less' and that this plagued both government and

non-government agencies. Suggestions were made that increasing pressure, reduced capacity and a decreasing availability of time, particularly in government community mental health teams, was fostering a clinical, and symptom-based approach. Additionally, participants identified a 'quick fix' mentality, which resulted in consumers being over-medicated to manage symptoms that had continued to escalate due to a lack of appropriate ongoing psychosocial support. Consumers and carers recounted personal experiences of this. It could be argued that a collaborative approach could more effectively utilise the limited resources available, and that through community-managed psychosocial services being more readily accessible and valued as equal in contribution to a person's recovery, the pressures on the system could be reduced. It could also be argued that this has the potential to be one part of an approach to challenge and reduce the identified 'risk averse' culture ingrained in the mental health sector. Through the use of a collaborative partnerships model, in which NGOs were no longer positioned as 'less capable', community mental health teams could focus on providing appropriate clinical support, managing medication more effectively and engaging support from professionals such as psychiatrists and mental health nurses as needed. A strong, well-resourced community-managed mental health sector could then provide the support needed to address broader social health needs, walking alongside consumers to reduce or prevent reoccurring crisis episodes.

The effects of competitive tendering on the structure and availability of resources, and questions about how these resources could be more effectively leveraged within the mental health sector, was a significant theme in this study.

Acknowledgement that 'it's the beast we must live with' was evident, with participants describing negative and positive aspects of the current model. Generally, there was a consensus that competitive tendering could be attributed to positively impacting the quality of services in most instances, and that the process had fostered a stronger, more evidence-based and articulate non-

government sector. However, frustrations with the system hindering the ability to collaborate due to positioning agencies and sectors in competition for funding far outweighed the perceived benefits. Notably, the creation and maintenance of silos was raised as one of the most damaging effects of competitive tendering.

Sector Stakeholder: Siloed funding means siloed departments; it supports the 'it's not our job' mentality and feeds ongoing power struggles within the bureaucracy.

It must be highlighted that when participants were asked to explore how to overcome this barrier they were unable to envisage an alternative system of funding for mental health services. Links to more specific and appropriate outcomes and measurement were made, with suggestions that instead of a 'cheapest price mentality', tenders should focus on outcomes, and that outcomes measures should be developed from a collective understanding of consumer need, who can best provide service to meet that need, and how that service can be undertaken in an integrated collaborative manner.

Working together: outcomes, indicators and measures

A view that the South Australian mental health sector currently focuses on the wrong indicators for measuring the impact of services and the contribution they have to individual's recovery journeys was interwoven in every theme identified in this research. A belief that the mental health sector, both in South Australia and nationally, only measures a small part of the effects of policies and services was noted. Linked to this was the view that focusing on measurements such as emergency department admissions, length of stay, and number of acute beds supports the aforementioned clinical discourse and allows it to continue to permeate and drive all aspects of mental health care.

Sector Stakeholder: What you measure is the focus, and if clinical outcomes are the measurement tool, clinical-based services are the focus.

Sector Stakeholder: We are not just dealing with an acute phase of illness, a person's life encompasses all their needs, from housing to employment to training to social connectedness to meaningful daytime activity, how do you create a set of KPIs for a whole of life perspective?

Although a 'best' model of measurement wasn't identifiable, it was suggested that a focus on the holistic wellbeing of individuals and a consideration of a community-driven mental health sector with collaborative, integrated approaches was needed. This echoes the recommendations of the COAG Expert Reference Group on Mental Health Reform (CERG) (2013) who developed six domains underpinned by a set of targets and indicators related to mental health as follows:

- more people with mental health problems will have better physical health and live longer
- more people have better mental health and wellbeing
- more people with mental health problems will live a meaningful and contributing life
- more people will have a positive experience of care and support
- fewer people will experience avoidable harm
- fewer people will experience stigma and discrimination.

It can be argued that these domains broadly represent the key priority areas identified in this research, suggesting a strong narrative and rationale exists in South Australia for the development of measurement tools, targets and indicators that position the consumer and their recovery needs as the core focus.

Recommendation 3: Develop outcomes and indicators that facilitate consumer-centred and recovery-oriented service delivery and collaborative approaches.

To implement this recommendation it is suggested that:

- the South Australian Mental Health Commission undertakes a review of the current outcomes, targets and measurements used within the South Australian mental health sector;
- new evidence-based measures and outcomes are developed that holistically reflect consumers' individual and unique recovery journeys alongside their clinical outcomes and symptoms;
- the South Australian mental health sector commit to these outcomes via a Charter facilitated by the South Australian Mental Health Commission;
- outcomes facilitate the ongoing development of partnerships between the community and acute mental health sectors;
- outcomes reflect and develop a commitment to whole of person approaches via cross-sector partnerships that support people in managing a range of social health needs;
- the State Government allocates funding based on these outcomes and prioritises resources for effective models of community-based support.

Key theme four: Them and us – a roadblock to recovery

Siloing linked to a theme of negative workforce culture in the mental health sector. This culture was described as pervasive, having a detrimental effect on the sector's ability to engage with reform towards more community-based services, and as impacting directly on client wellbeing. 'Turf protection' was a term used by several participants in describing how the various silos from across sectors (e.g. participants noted separation of drug and alcohol services and mental health services as well as accommodation, employment and education) and between clinical and psychosocial mental health services continue to contribute to the aforementioned fragmentation of the mental health system. Participants described an unwillingness to share information with or exit consumers to other services, as well as an ongoing tension surrounding the impact and influence of clinical discourse within the mental health sector. It can be surmised that these accounts of attempts to stake ownership over a professional patch and in turn exert power and control within the field depict a roadblock to implementing a connected, collaborative stepped system.

Participants provided further evidence for this, stating that the clinical mental health sector had loudly voiced criticism of the stepped model. Stakeholders also stated that upon the dismantling of the SA Social Inclusion Board, any initiative that gave perceived power to the community-managed sector in order to rebalance the system was discontinued or 'tokenistic'. Participants alluded to an 'old guard' as a contributing factor to ongoing patch protection. Concerns were expressed that these 'old guard' workers were unwilling to engage with reform despite strong evidence that a community-based system is a more effective approach to mental health support. These people were described as resistant to embracing newer approaches to mental health care practice. It was noted that a significant retraining exercise was required across the mental health sector to challenge this culture built of 'expertism' and narrow, often clinically-focused

service delivery. Carter, Burke and Moore noted similar resistance in the implementation of the Returning Home programme (2008, p.62).

Of particular importance in terms of workforce culture, consumers and carers who participated in this study identified similar concerns and discussed experiences of workers being disengaged, uninterested and dismissive, which they attributed to 'being in the job too long'. They reported that these experiences made them hesitant to engage with the system or had resulted in them exiting a service due to feeling disempowered and unheard. Closely linked to this was an experience of stigma towards consumers from workers, which was described as having a direct, negative and damaging effect on consumers' mental health. Carers also spoke of experiencing stigma towards themselves and those they care for.

Carer: They just assume you're going to be difficult when you present at emergency with them, the response is always over the top and disrespectful. If I could change anything it would be the workers, getting them to see my son as a person first, to see me as a person first.

This stigma has recently been documented in studies exploring youth self-harm (Robinson, McCutcheon, Browne & Witt, 2016), and this research echoes consumer experiences of feeling judged as not being 'really sick', or that their illness/self-harm injuries were not as valid or important as other health problems at emergency departments and in primary health services more broadly.

Sector Stakeholder: In relation to self-harm, there's this stigma in the clinical sector where emergency department staff feel like their time is being taken up by someone who has harmed themselves instead of someone who has been harmed in other ways.

Mental health sector stakeholders described the stigma experienced by consumers as an insidious challenge that continues despite ongoing education and training. Notably, recent consultations undertaken by the Adelaide PHN also reported workplace culture and experiences of stigma as key concerns for those they spoke with (2016). The identified negative workforce culture said to marginalise consumers and carers was also highlighted as an ongoing problem between workers. Participants stated that an unrecognised number of workers in the mental health sector, ranging from case managers to psychiatrists, are themselves experiencing mental illness and are unable to seek help, engage in peer work, or identify as 'lived experience' for fear of being stigmatised and seen as being incapable of doing their job. This is at odds with a mental health sector that has recognised the positive contribution of the 'lived experience' workforce in supporting consumers to achieve their recovery journey goals. Reflecting a wide body of existing literature, those interviewed for this study spoke of peer work as the most 'exciting thing' in the mental health sector, and positioned it as a role which engages consumers 'where they are at'. This high regard for peer work was echoed in consumer and carer focus groups.

Consumer: I wouldn't have survived the system without one.

The ability for those with lived experience to empathise and connect with the consumer was highly regarded and suggestions of broadening the availability of peer workers through embedding them into service structures and contracts were proposed. Furthermore, embracing lived experience across all mental health roles was advised and mental health sector stakeholders, consumers and carers all enthusiastically supported advertising openly for people with lived experience to apply for positions.

The opinions gathered in this study describe a 'them and us culture' between workers and consumers and also between agencies and co-workers. This was

emphasised in descriptions of a system in which service quality, particularly in relation to collaborative partnerships at both consumer and agency level, often depended on ‘who you spoke to on the day.’ It was said that having an effective, positive interaction was primarily dependent on the individual worker, and that stigma, ‘turf protection’, and the siloing of roles and responsibilities all acted as barriers to consumers in South Australia. For a more respectful and consumer-focused system to be developed, there is an undeniable need to challenge ingrained stereotypes about mental illness within the workforce; invest in significant re-training with a focus on cross-sector knowledge sharing; review and performance manage existing employees; and, where required, recruit new staff with appropriate values, skills and knowledge to refresh the mental health sector. Investing in the lived experience workforce and ‘normalising’ lived experience within the mental health sector and at a broader community level would be an important step towards working from a holistic, person first approach.

Recommendation 4: Invest in training and facilitate the development of cross-sector knowledge and networks to challenge the stigma attached to mental illness by the workforce.

Recommendation 5: Invest in engagement with, and development of, the lived experience workforce.

To implement these recommendations it is suggested that:

- the mental health sector continues to support and implement the upskilling, support and development of a qualified and appropriately remunerated workforce;
- stronger cross-sector networks are developed through collaborative services and training;

- commitment is made to investing in appropriate training and ongoing supervision for employees to challenge stigma and discrimination, facilitate respectful consumer-centred approaches, and educate the workforce about the important contribution, unique skill and expertise that lived experience and peer workers make to consumer recovery journeys;
- the unique expertise and skills of the lived experience workforce are recognised in recruitment and remuneration policies and through the provision of resources to ensure ongoing support and development opportunities;
- the peer worker role is expanded, allowing consumers access to peer workers at every level of support in a stepped system of care;
- the development of the peer workforce is facilitated via subsidised training and the infrastructure and resources needed to provide ongoing support and training.

Key theme five: Consumer and carer voice – the missing piece

Despite this theme being the last of those addressed in this research, it is unequivocally the most important. The ongoing frustration experienced by consumers who feel stigmatised, unheard and undervalued as the experts of their own mental health was a theme interwoven throughout every interview, as well as in the focus groups. Despite person-centred approaches being recognised as best practice internationally, and a well-supported consumer movement that advocates, ‘nothing about us without us’, those who volunteered for this study described a system that both ignored and actively silenced the voices of consumers at micro and macro levels. Consumers relayed experiences of workers disregarding their feedback or wishes, and carers told of a mental health

sector in which those supporting people with mental illness are 'used to suit the system' and 'fill the gaps', yet ignored when they voice concerns or ask for help. Privacy was noted by carers and stakeholders as a tool used to avoid genuine engagement with carers, suggesting that services are disregarding the valuable knowledge those with significant relationships to consumers can provide to assist in diagnosis and treatment. It was acknowledged that those experiencing mental illness have a right to privacy, but that this should not prevent a service receiving information. It was suggested a system-wide education programme clearly detailing 'what can be done' rather than 'what can't be done' be undertaken to facilitate better communication between carers and workers.

Carer: 'I can't talk to you because of privacy' can come from fear of getting it wrong, but it's also used as an excuse for lack of time, lack of knowledge, lack of skills and in worse cases, I can't be bothered or care about dealing with you.

Stakeholders acknowledged an ongoing system failure in hearing the voices and recognising the expert knowledge of consumers and their carers regarding their needs and health. They advocated that any reforms to the system must engage the voice of consumers and carers as equal in value and importance. Stakeholders noted that consumer and carer voices should be embedded in all mental health related decision making processes as standard practice, rather than as advisory groups with tokenistic input into policies and services. Of significant note, when asked to provide one piece of advice to the Mental Health Commission every single participant, both in interviews and focus groups, responded with a clear message: **listen to those experiencing mental illness, listen to those who support them and listen to the communities they are a part of**. This speaks volumes about the necessity of a mental health system to not only provide quality, appropriately balanced psychosocial and clinical services at both the community and acute levels, but to build this service on the expressed needs, desires and knowledge of the people who it is intended support.

Recommendation 6: Develop stronger avenues through which the voices of consumers and carers can be heard, and place these at the centre of policy and service development.

To implement this recommendation it is suggested that:

- system reforms are undertaken via a process of co-design, in partnership with consumers and carers;
- consumers and carers are engaged in an expert role as part of the governance structure of the South Australian Mental Health Commission and within SA Health;
- the use of consumer and carer participation is standard practice in governance, development, evaluation and tendering in regards to programmes and services in the mental health sector;
- expert knowledge and input from mental health consumers and carers is sought across sectors to ensure representation of the consumer voice in all social health issues that factor into an individual's mental wellbeing;
- appropriate remuneration is provided to consumers and carers in recognition of their contribution in consultation or advisory roles;
- investment is made into implementing consumer- and carer-centred policies and training across the South Australian mental health sector to ensure the integration of consumer and carer input is respected and supported;

- investment is made to ensure that consumers and carers engaged in expert advisory or consultation roles have access to ongoing support, peer supervision and development opportunities to enhance their skills and contributions to policy and practice.

Conclusion

Utilising a qualitative, collaborative research approach and engaging a broad range of people from the South Australian mental health sector, the findings of this project have highlighted a strong, ongoing narrative of those that use, implement and contribute to the development of mental health services. The consistency of this narrative, from consumers and carers, to government and non-government, clinical and psychosocial stakeholders speaks volumes as to the reform that must be undertaken: the sector is frustrated and, in many ways, tired of advocating for a shift of focus to the potential and capacity of community-based services. It calls for processes and policies to 'jigsaw' this potential with clinical and acute services.

The described stigma and discrimination throughout the mental health sector is alarming and, if not addressed, will have detrimental effects on consumers' recovery journeys. There is an urgent need to focus on this area, and it is clear that expanding the lived workforce broadly, as well as focusing on specific peer work roles, has a vital part to play in undertaking this reform. It can be proposed that the implementation of a holistic, person-centred set of targets and measurements, reflecting a broad range of social health needs in addition to symptom/cost efficiency-based indicators will also contribute to reducing these concerns and encourage the ongoing improvement of services. It must be noted that these measurements and targets cannot be developed without the equal contribution of those who experience mental illness, and those who care for them. A recognition that the sector does not adequately listen to or engage the voices of

consumers and carers was a clear concern for those who participated in this project, and this must be reviewed at all levels of the system. The need for reform to be undertaken in a collaborative, integrated manner across sectors via a co-design process with consumers and carers was clearly identified. Engaging consumer and carer participation in governance and decision-making as standard, and facilitating their contribution through appropriate training, support and remuneration is a key recommendation of this report, and should underpin all reform initiatives in the sector. Possible benefits, for both the consumer's recovery journey and cost efficiency to the system, are numerous, evidenced in the accounts gathered, as well as previous research and evaluation in the field.

An integrated, stepped system, particularly in accommodation options, was still supported, with participants speaking to the success of partnership models that wrap around consumers' social health needs, such as HASP and IPRSS. Of note, a subacute level of care was still advocated for by sector stakeholders and consumers and carers, who proposed that these services must be implemented effectively to act as a step between community- and acute-based services. This report accordingly recommends that the South Australian Government refrains from any reduction of service in this area and instead seeks to refocus on clarity of roles, process and the provision of sufficient resources to expand these collaborative, community-managed options.

Despite this study revealing barriers to 'any door as the right door' for consumers, including segmented silos and a disproportional focus on one facet of service delivery, the desire to see a more flexible, connected and integrated system was clear. The optimism for and willingness to engage in cross-sector partnership is evidence that the sector is ready for change.

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