



Social Inclusion

Its importance to mental health



Mental Health
Coordinating Council

Supporting community organisations
working for mental health
throughout NSW

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Foreword

This document is about the importance of social inclusion to good mental health. It is also about effective and responsive community-based approaches to good mental health.

Social inclusion is about being able to participate in and contribute to all aspects of a society that genuinely includes people living with mental illness; that supports, intervenes and prevents crises; and that does not discriminate or stigmatise. Community-based organisations are well placed to make the principles of social inclusion real within communities.

This paper summarises the evidence linking community-based strategies with recovery, and the evidence linking social inclusion with positive mental health. In doing so, it places the community in its broadest sense at the heart of each individual's experience of their own mental health. Social inclusion is central to promoting mental health and minimising the disability associated with mental illness.

The paper articulates the value and place of the non government sector as an integral part of the mental health care landscape in NSW, as well as in the social fabric of community, particularly in relation to its essential role in promoting and enabling social inclusion.

Whilst the meaning and principles of social inclusion may be well understood in theory, it can be seen as a challenge to consider how we can actually foster social inclusion for people in our daily work. This paper looks at the work done by NGOs in the community, and argues that it is precisely this kind of work that does in fact support consumers through social inclusion principles and practices – through working to re-engage people with society through practical and psychosocial support, as well as applying an underlying philosophy, culture and approach that sees the individual as the key driver of her/his own recovery journey.

Of course, enabling social inclusion for all goes beyond the role and capacity of the non government sector, and the whole of society has a vital role. Whilst this is obviously beyond the scope of a paper such as this, we do argue for a whole-of-government approach to setting policy in line with this goal. The perception of mental illness within society is plagued with misinformation, assumptions, negative stereotypes, and a strong sense of those living with mental illness as “other”. We argue for changes to this perception by putting into place proper support systems within the community for people living with mental illness, their families and friends, to promote mental health and wellbeing, and to promote positive images of people living fulfilling lives regardless of their mental health status.

This is an achievable aim. Our governments can do this now, and we offer some clear direction. It needs well directed funding and programs delivered in a sustainable manner. Programs that support and enable self determination for all.

This does not just promote individuals' mental health, but the mental health of the whole community.



JENNA BATEMAN

Executive Officer, MHCC

If we plant a seed in a desert and it fails to grow, do we ask, “What is wrong with the seed?” No. The real conspiracy lays in this: to look at the environment around the seed and to ask, “what must change in this environment such that the seed can grow?” The real conspiracy that we are participating in here today is to stop saying what’s wrong with psychiatric survivors and to start asking: “How do we create hope filled, humanised environments and relationships in which people can grow?”

DR PATRICIA DEEGAN,

Keynote Address, TheMHS Conference,
1996, Brisbane

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Introduction

Our mental health system is struggling to meet need, so what should we do? The most common response is for more psychiatric hospital beds – but is this really the answer?

Not surprisingly, the general public has lost confidence in community-based mental health care because it has been done poorly, and the shifting of demand from hospital to community has not been planned or resourced properly.¹ The prevalence of mental illness among homeless and prisoner populations is often cited as a tragic outcome of this phenomenon.

However, community-based support is the right approach – it just needs to be better planned and resourced, with more ready access to community services and better links to the hospital system and other necessary services.

Consistently, studies show that people living with mental illness who are provided with well-planned, comprehensive support in the community have a better quality of life,² develop an improved level of functioning³ and social contact,⁴ and have fewer relapses.⁵

People living with mental illness must have the opportunity to be not just patients, but individuals with complex lives and needs. Participation in society improves mental health, self-determination, and general functioning.⁶ On a broader social level, it reduces discrimination and stigmatisation,⁷ both essential to achieving and maintaining good mental health.

De-institutionalisation has strong momentum internationally, and experts are consistent in supporting community-based care complemented by hospital beds for acute care as required. The World Health Organization, for example, recommends shifting care

- 1 Mental Health Council of Australia (2005) *Not for service: Experiences of injustice and despair in mental health care in Australia*; Groom G, Hickie I, and Davenport T (2003) *Out of hospital, out of mind!* Mental Health Council of Australia, Canberra
- 2 Meehan T, Robertson S, Stedman T, and Byrne G (2004) Outcomes for elderly patients with mental illness following relocation from a stand-alone psychiatric hospital to community-based extended care units, *Australian and New Zealand Journal of Psychiatry* 38(11-12): 948-52; Hobbs C, Newton L, Tennant C, Rosen A, and Tribe K (2002) Deinstitutionalization for long-term mental illness: A 6-year evaluation, *Australian and New Zealand Journal of Psychiatry* 36(1):60-6; Priebe S, Hoffmann K, Isermann M, and Kaiser W (2002) Do long-term hospitalised patients benefit from discharge into the community? *Social psychiatry and psychiatric epidemiology* 37(8): 387-92; Trauer T, Farhall J, Newton R, and Cheung P (2001) From long-stay psychiatric hospital to Community Care Unit: evaluation at 1 year, *Social psychiatry and psychiatric epidemiology* 36(8): 416-19; Dixon L, Goldberg R, Lehman A, and McNary S (2001) The impact of health status on work, symptoms, and functional outcomes in severe mental illness, *The Journal of nervous and mental disease* 189(1): 17-23; Hobbs C, Tennant C, Rosen A, Newton L, Lapsley H, Tribe K, and Brown J (2000) Deinstitutionalisation for long-term mental illness: a 2-year clinical evaluation, *Australian and New Zealand Journal of Psychiatry* 34(3): 476-83; Leff J, and Trieman N (2000) Long-stay patients discharged from psychiatric hospitals: Social and clinical outcomes after five years in the community, *British Journal of Psychiatry* 176: 217-23
- 3 Grinshpoon A, Naisberg Y, and Weizman A (2006) A six-month outcome of long-stay inpatients resettled in a hostel, *Psychiatric Rehabilitation Journal* 30(2): 89-94; Hobbs et al. (2002), op. cit.; Hobbs et al. (2000), op. cit.
- 4 Meehan et al. (2004), op. cit.; Dixon et al. (2001), op. cit.; Leff & Trieman (2000), op. cit.
- 5 Dixon L, and Lehman A (1995) Family interventions for schizophrenia, *Schizophrenia Bulletin* 21(4): 631-43
- 6 Waghorn G and Lloyd C (2005) *The employment of people with a mental illness: a discussion document prepared for the Mental Illness Fellowship of Australia, University of Queensland*; Bond, G, (2004), Supported employment: evidence for an evidence-based practice, *Psychiatric Rehabilitation Journal*, 27(4): 345-59; Bond G, Becker D, Drake R, Rapp C, Meisler N, Lehman A, Bell M, and Blyler C (2001) Implementing supported employment as an evidence-based practice, *Psychiatric Services* 52(3): 313-22
- 7 Mueller B, Nordt C, Lauber C, Rueesch P, Meyer P, and Roessler W (2006) Social support modifies perceived stigmatization in the first years of mental illness: a longitudinal approach, *Social Science and Medicine* 62(1): 39-49; Boardman J (2003), Work, employment, and psychiatric disability, *Advances in Psychiatric Treatment* 9: 327-34

away from psychiatric hospitals, developing community mental health services, and integrating mental health services into general health care.⁸

What this means in practice is a network of services in the community to address each person's 'whole of life' needs, which vary considerably. These include supported residential services, vocational rehabilitation agencies, community centres providing social and recreational activities and linking people to other services, respite and other support for carers, information and education. We have this system now in Australia, but it has nowhere near enough resources to meet demand.

25 years of de-institutionalisation has not been backed up with nearly enough community services. One outcome is a 'revolving door' phenomenon, where people are treated in hospital, discharged with inadequate support, become unwell, and return to hospital again, in an ongoing cycle. Meanwhile, their families and friends are under pressure to fill the gaps in necessary care. Carers are at risk of mental health problems, as they experience anxiety, guilt, helplessness, and at times, fear for their own safety or that of those around them.

Respite for carers can be achieved outside the hospital system. Timely intervention and support should provide carers with time, space, and peace of mind. Enough community-based supported accommodation places should be available for consumers who cannot live at home, either for a short or extended time; places where they can feel welcome and safe, and where realistic linkages to the community may be achieved.

The non-government (NGO) sector in Australia is ideally placed to provide comprehensive community-based support for consumers and carers, but it requires greater resourcing. In New Zealand three quarters of all funded services are community-based, and 31% of total expenditure is on NGOs. Emphasis is on planned, coordinated care, focusing on social inclusion, active involvement of people in their recovery, and personalisation of services to meet need.⁹

This figure compares with the national average percentage spending on NGOs in Australia of 6.2%.¹⁰

The New Zealand government recognises that a "vibrant and sustainable community sector ... is fundamental to an efficient and effective mental health system that supports recovery of service users."¹¹

In NSW, significant improvements in clients' quality of life, community participation and mental health have been demonstrated by supported accommodation programs such as the Housing and Accommodation Support Initiative (HASI). Agencies participating in HASI provide a range of services to meet the clients' needs in the community.

- ⁸ World Health Organization (2003), *Organization of services for mental health*, World Health Organization
- ⁹ Counties Manakau website http://www.cmdhb.org.nz/Counties/News_Publications/Planning-documents.htm. Accessed 30 October 2006
- ¹⁰ Department of Health and Ageing (2005) *National Mental Health Report 2005: Summary of ten years of reform in Australia's mental health services under the National Mental Health Strategy, 1993 – 2003*, Commonwealth of Australia, p. 5
- ¹¹ Mental Health Commission (NZ) (2006), *Report on progress 2004/05: towards implementing the Blueprint for Mental Health Services in New Zealand*

“People provided with well-planned, comprehensive support in the community have a better quality of life, develop an improved level of functioning and social contact, and have fewer relapses”

Importantly, the program is indicating a significant decrease in demand for acute hospital services, and the 'revolving door' phenomenon has all but disappeared, as most hospital admissions are planned, not unplanned.¹²

Supporting each individual's recovery process and preventing relapse has significant benefits for the individual, their family and friends, and the whole community, largely through the reduction of negative impact. It halts the erosion of confidence and wellbeing, it prevents the development of further disability, and increases productivity and the cultural and economic life of communities.¹³

Our mental health system can provide a quality service, but we need more investment in community-based support services, and better coordination between hospitals and the range of community services. Over the last decade, Australian government spending on mental health has been less than 7% of the total health budget when it needed to be at least 12% annually. The proportion spent on community-based agencies, which in 2005 was currently less than 7%, needs to double to at least 15% to meet the demand.¹⁴ The impact of the 2006 Coalition of Australian Governments (COAG) announcements sees this percentage raised by only 1%-2%, to approximately 8%.¹⁵

In a recent Australian study, Carr and colleagues present compelling evidence for the economic benefits of government investment in community-based interventions for psychosis. Their main findings were that the costs of care were "extremely high", with the main driver the cost of hospitalisation. They conclude: "we appear to be spending disproportionate amounts on 'housing' people in hospitals and not investing sufficiently in supported community accommodation".¹⁶ They also conclude that investment in evidence based psychosocial interventions would see better outcomes for consumers, as well as considerable savings for the health budget.

We are currently seeing some long overdue changes in government policy, with an increased commitment on investing in community services. This is a welcome change for the under-resourced community sector, but there is still a long way to go before the system is right. There is still also work to be done to educate the general public about mental illness and the place of social inclusion in people's recovery process.

This paper seeks to clarify the place of community-based approaches in promoting social inclusion for people with mental health problems. It complements the MHCC resource *Working on Strengths*, which covers in more detail the specific research-based evidence for NGO-based programs and their effectiveness, and advocates the need for greater focus on research into community-based psychosocial interventions comparable with the focus on research into clinical approaches.

- 12 Social Policy Research Centre (2006), *Housing and Accommodation Support Initiative Report II*, Report prepared for the NSW Department of Health, Sydney
- 13 Rickwood D (2006), *Pathways of Recovery: Preventing further episodes of mental illness (Monograph)*, Commonwealth of Australia, Canberra, Canberra, p. 17-19
- 14 Mental Health Council of Australia (2005), op. cit., p.17
- 15 Mental Health Council of Australia (2006), *Weaving the Net: Promoting mental health and wellness through resilient communities*, Canberra
- 16 Carr V, Neil A, Halpin S, and Holmes S (2002), *Costs of psychosis in urban Australia: National Survey of Mental Health and Wellbeing Bulletin 2*, Canberra, p. 35

“The non-government (NGO) sector in Australia is ideally placed to provide comprehensive community-based support”

Defining terms and establishing some basics

It is now well known that an important part of having and maintaining good mental health lies in feeling included within society. For people living with a mental illness, social inclusion plays a central role in recovery.

In relation to this, the literature tells us four main things:

1. recovery from mental illness does occur;
2. social inclusion aids recovery;
3. social exclusion impedes recovery; and
4. attitudes of other people strongly influence how well people recover.

After defining the key terms of social inclusion and recovery, this section will outline the main evidence relating to these four points in turn.

WHAT IS SOCIAL INCLUSION?

Social inclusion is about being able to participate in and contribute to social life – in economic, social, psychological, and political terms. To do this requires having personal capacity as well as access to employment and/or other social roles.

It is also helpful to consider social inclusion in relation to what it is not, and enhancing social inclusion is enriched by decreasing social exclusion. The UK Social Exclusion unit states:

Social exclusion is ... a short-hand term for what can happen when people or areas have a combination of linked problems, such as unemployment, discrimination, poor skills, low incomes, poor housing, high crime and family breakdown. These problems are linked and mutually reinforcing. Social exclusion is an extreme consequence of what happens when people don't get a fair deal throughout their lives, often because of disadvantage they face at birth, and the disadvantaged can be transmitted from one generation to the next.¹⁷

Social exclusion can result from a single factor or a number of factors. Mental illness is closely associated with social exclusion due to a number of factors, mainly socially-derived, that have been attached to it, including fear, misunderstanding, stigma, discrimination, and an entrenched belief that the appropriate medical and social response is separation from society.

WHAT IS RECOVERY?

Recovery principles are central to understanding the importance of social inclusion to mental health.

Pat Deegan, a psychologist with schizophrenia, defines recovery as “rediscovering meaning and purpose after a series of catastrophic events which mental illness is”. A diagnosis of mental illness can result in the loss of social status, income, friends, family, and sense of identity. It can lead to feelings of hopelessness, meaninglessness, and helplessness.

¹⁷ UK Social Exclusion Unit, *Context for social exclusion work*, sourced at www.cabinetoffice.gov.uk/social_exclusion_task_force/context/

Defining terms and establishing some basics

Therefore, it makes sense that instead of focusing primarily on symptom relief, as indicated by biomedical models, it is necessary to work to re-establish self-esteem and identity and a meaningful role in society. Deegan suggests “recovery is a process, a way of life, an attitude, and a way of approaching the day’s challenges ... The aspiration is to live, work, and love in a community in which one makes a significant contribution”.¹⁸

Recovery does not necessarily mean the absence of mental illness. It is about developing individual ways to lead a fulfilling life whilst managing the effects of mental illness. William Anthony says: “a person with mental illness can recover even though the illness is not “cured” ... [Recovery] is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness.”¹⁹

Although there are many pathways to recovery, several factors stand out. They include a home, a job, friends and integration in the community. They also include hope, relearned optimism and self-sufficiency.

THE ESSENTIAL COMPONENTS OF RECOVERY

Recovery is grounded in principles of individuals’ empowerment and involvement in their own recovery journey.

The following basic components of a recovery framework have been identified:²⁰

- Individualised approach to care, respecting each person’s expertise in and capacity to manage their own health;
- Whole person focus, not just on symptoms;
- Self direction - consumer and family have direct and ongoing input into interventions;
- Trust – someone to be there at times of need;
- Hope;
- Strengths based;
- Recovery can occur even when symptoms reoccur;
- Recovery is often episodic, not necessarily linear;
- Individual responsibility;
- Both a process and an outcome.

¹⁸ Deegan, 1988, p. 15

¹⁹ Anthony, 1993

²⁰ Office of the Public Advocate - Queensland (2004), *Annual Report 2003-04*, p. 30; US Department of Health and Human Services (undated), *National Consensus Statement on Mental Health Recovery*, accessed at www.samhsa.gov

1. RECOVERY OCCURS

The 1990s has been labelled the “decade of recovery”,²¹ as it was during this period that the concept of recovery gained credibility, largely through the emergence of consistent evidence that showed people can recover from mental illness, and, following the initial onset of mental illness, further episodes can be prevented.

Prior to this, it was generally thought that recovery did not routinely occur, and this informed how mental health systems were set up and run.²² It was thought that the condition of people diagnosed with mental illness would, at best, remain constant, and at worst, deteriorate, and mental health systems were therefore designed to maintain people in a state of illness rather than focusing on how to enable and support recovery. In this context, it is clear to see the thinking behind the concept of asylum and indefinite detention.

Today, the process of recovery is an expectation following a diagnosis of mental illness if people are provided with quality care and support. This evidence has come from consumer accounts and a series of outcomes studies.²³

As Mead and Copeland state:

Now the times have changed. Those of us who have experienced these symptoms are sharing information and learning from each other that these symptoms do not have to mean that we must give up our dreams and our goals, and that they don't have to go on forever. We have learned that we are in charge of our own lives and can go forward and do whatever it is we want to do. People who have experienced even the most severe psychiatric symptoms are doctors of all kinds, lawyers, teachers, accountants, advocates, social workers. We are successfully establishing and maintaining intimate relationships. We are good parents. We have warm relationships with our partners, parents, siblings, friends and colleagues. We are climbing mountains, planting gardens, painting pictures, writing books, making quilts, and creating positive change in the world.²⁴

Consumer accounts, particularly in the USA, have provided compelling personal stories of a broad range of “the many and varied individual pathways of recovery”.²⁵ Unzicker, for example, has told her recovery story, a journey from 10 years of “pills, shrinks, labels, powerlessness and hopelessness” to a position of wellness, engaged and active in society. Dr Daniel Fisher, a psychiatrist with a history of hospitalisation for schizophrenia, became a strong advocate for recovery and consumer empowerment, and openly discusses his recovery in presentations and publications. There are

²¹ For example see Rickwood (2006), op. cit.

²² Anthony W (2000) A recovery-oriented service system: setting some system level standards, *Psychiatric Rehabilitation Journal* 24(2): 159

²³ Rickwood (2006), op. cit., p. 16-17; Anthony (2000), op. cit.

²⁴ Mead S and Copeland ME (2000), *What recovery means to us*, Plenum Publishers, New York. Accessed online at <http://www.mentalhealthpeers.com/pdfs/WhatRecoveryMeansToUs.pdf> on 11 January 2007. p. 2

²⁵ Rickwood (2006), op. cit., p. 16

“Those of us who have experienced these symptoms are sharing information and learning from each other that these symptoms do not have to mean that we must give up our dreams and our goals, and that they don't have to go on forever.”

numerous other examples including Deegan, Leete, and more recently, the Inner East Mental Health Services Association (Victoria), and Nelson et al.²⁶

In the late 1980s and early 1990s, Harding and colleagues were among the first to conduct outcomes studies showing people diagnosed with severe mental illness were recovering. Their Vermont longitudinal study of long term outcomes of people diagnosed with schizophrenia in the 1950s showed that more than 60% of the sample of 118 consumers had fully or largely recovered.²⁷ In a subsequent paper that compared the findings of five long-term outcomes studies, Harding et al found that the papers consistently showed between half and two thirds of patients recovered.^{28 29}

Alongside this came improvements in medications, a greater acceptance that people can be involved in their own care, the rise of complementary health care approaches, and an increased focus on human rights, which all lent further support to the idea that long term institutionalisation is unacceptable and, in most cases, unnecessary.

2. SOCIAL INCLUSION IS GOOD FOR MENTAL HEALTH AND RECOVERY FROM MENTAL ILLNESS

Social relationships and social support are important for good mental health for all people, and for those recovering from mental illness, re-connection with society promotes recovery and decreases the chance of relapse.³⁰

Social connections include engaging with friends and peers, maintaining employment and economic wellbeing, undertaking education, art, hobbies, and other activities, physical exercise, leisure and recreation, and social relationships. Engagement in society encapsulates the principles of having a sense of purpose and agency, feeling safe and secure, being free from violence or the threat of violence, and having hope for the future.³¹

There is little prospect of accessing work or community activities by people whose housing is unstable, who have problems with money, who are unable to access affordable transport, and who feel isolated by stigma and discrimination (actual and/or feared).

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- 26 Deegan P (1988), Recovery: the lived experience of rehabilitation, *Psychosocial Rehabilitation Journal*, 11(4), 11-19; Leete E (1989), How I perceive and manage my illness, *Schizophrenia Bulletin*, 15(2): 197-200; and more recently: Inner East Mental Health Services Association Inc – Terra Firma (2003), *Recovery Paths: An anthology of personal journeys of hope*, Terra Firma, Victoria (Australia); Nelson G, Lord J, and Ochocka J, (2001), Empowerment and mental health in community: Narratives of psychiatric consumer/survivors, *Journal of Community and Applied Social Psychology* 11(2): 125-42
- 27 Harding C, Brooks G, Ashikaga T, Strauss J, and Breier A (1987), The Vermont longitudinal study of persons with severe mental illness II: Long-term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia, *American Journal of Psychiatry*, 144(6): 727-35
- 28 Harding C, Zubin J, and Strauss J (1992), Chronicity of schizophrenia revisited, *British Journal of Psychiatry* 161(Suppl 18): 27-37.
- 29 The measure of “recovery” used was: “no signs or symptoms of any mental illness, no current medications, working, relating well to family and friends, integrated into the community, and behaving in such a way as to not be able to detect ever having been hospitalized for any kind of psychiatric problem”, Harding C, and Zahniser J (1994), Empirical correction of seven myths about schizophrenia with implications for treatment, *Acta Psychiatrica Scandinavica Supplementum* 90(Suppl 384): 140-46.
- 30 Social Exclusion Unit (UK) (2004) *Mental Health and Social Exclusion*, London
- 31 For a good discussion of these issues, see Rickwood (2006), op. cit., pp. 37-43

People with mental illness are more likely to have smaller social networks³² (average size is 5 to 13 people) than the general population (25 people), and their network tends to decrease in size as the duration of illness increases.³³

A number of studies have confirmed the link between social inclusion and recovery from mental illness. Pevalin and Goldberg, for example, in a large-scale UK study of over 15,000 people, demonstrated that low social support increased chances of onset and decreased chances of recovery.³⁴

In a recent New Zealand survey with people who had recovered from mental illness, help from others was by far the most frequently mentioned theme, and all 40 participants identified assistance from other people as important to their successful recovery. Family and mental health workers were the most common source of help, and each was mentioned by over half. More than half also referred to help received from groups, including support groups and therapy groups.³⁵ Another study found that friends were rated by consumers as the most important contributing factor to staying well.³⁶

Part of the recovery framework includes working on the broader impact that mental health problems can have on an individual's life. This includes the impact of losing a job, interrupted schooling, and losing contact with friends and family. It also includes the increased sense of isolation that other people's attitudes to mental illness can bring.

Mental illness can also have a devastating impact on functioning which contributes to the ongoing level of disability. Functioning includes the activities of daily living such as preparing food, maintaining hygiene, taking care of one's living space, having a routine – in other words, those basic skills required for community living.³⁷

While it is clear a reduction in symptoms is necessary for recovery, it has been increasingly recognised that many people need help to build or re-build their ability to function well, as improved functioning does not automatically follow a decrease in symptoms. This can require the support of a number of different kinds of support agencies. Consumers and carers value improved functioning very highly, and one study found that they value this more highly than improvement in symptoms.³⁸

“Social relationships and social support are important for good mental health for all people”

32 Defined by Harvey and colleagues as “the organisation of people’s ties to one another, the frequency of their contact with various network members, and in particular the number of relationships or social roles a person has” (Harvey C, Evert H, Herrman H, Pinzone T, and Gureje O (2002), *Disability, Homelessness and social relationships among people living with psychosis in Australia: Low Prevalence Disorder component of the National Study of Mental Health and Wellbeing Bulletin 5*, Commonwealth Department of Health and Ageing, p. 55)

33 Ibid., p. 55

34 Pevalin D, and Goldberg D, (2003) Social precursors to onset and recovery from episodes of common mental illness, *Psychological Medicine*, 33(2): 299-306

35 Lapsley H, Nikora L, and Black R (2002), “*Kia Mauri Tau!*”: *Narratives of Recovery from Disabling Mental Health Problems*, Report of the University of Waikato Mental Health Narratives Project, Mental Health Commission, Wellington, p 60

36 Joyce B, Staley D, and Hughes L (1990), Staying well: factors contributing to successful community adaptation, *Journal of Psychosocial Nursing and mental health services*, 28(6):18-24

37 Harvey et al. (2002), op. cit., p. 7

38 Ibid.

The central role of engagement and functioning in society to recovery from mental illness can make the recovery process quite complex, and we need to be working with each individual to identify what their needs are, including both medical and social. This calls for a multi-layered approach, well beyond what is possible within the biomedical model alone. The Sainsbury Centre for Mental Health offers a useful framework, identifying three different ways of thinking about inclusion and how this might be applied for each person's recovery process: a) as access to information and decision-making; b) as standard of living, including health, opportunities to learn skills, earn a wage, and live in safety; and c) as relationships with others replacing dependence on the mental health system.³⁹

3. SOCIAL EXCLUSION IMPEDES RECOVERY

"To be a mental patient is to become a no-thing, in a no-world, and you are not"⁴⁰

The experience of mental illness can be profoundly isolating, and this is only made worse when combined with the additional experiences of social stigma and isolation.

People diagnosed with a mental illness can enter a vicious cycle of social isolation. The diagnosis can be alienating, which can make the consequences of the diagnosis worse, which can lead to greater isolation, and so on. Stigma and social rejection are strongly linked to this vicious cycle, and one outcome of this cycling is limited access to health treatment and to justice,⁴¹ presenting almost impenetrable barriers to recovery.

Consumers commonly report difficulties with making and sustaining relationships, maintaining formal and informal networks, and managing tasks of daily living. These difficulties can exacerbate feelings of low self-esteem and lack of agency, which spirals into serious exclusion and isolation. Their lives can become "dominated by a fight to overcome personal and social problems and access appropriate support".⁴²

In the context of mental health care, when people are isolated from the general community during their recovery, they can become trapped in a system that "reinforces social stigma, reduces access to normative feedback and resources, encourages passive adjustment, and solidifies social withdrawal"⁴³

In other words, isolation during illness and recovery adds to the burden of the illness, and directly impedes the healing process.

“Isolation during illness and recovery adds to the burden of the illness, and directly impedes the healing process”

³⁹ The Sainsbury Centre for Mental Health (2002), *Working for Inclusion*, London

⁴⁰ Unzicker R (1989), On my own: A personal journey through madness and re-emergence, *Psychosocial Rehabilitation Journal* 13(1): 77

⁴¹ Sainsbury Centre for Mental Health (2000), *On your doorstep: Community organisations and mental health*, London, p. 8

⁴² Mind (2003), *Mental health and social exclusion: the Mind response*, Mind, London

⁴³ Ridgway P (2001), ReStorying psychiatric disability: learning from first person recovery narratives, *Psychiatric Rehabilitation Journal*, 24(4): 335-43

4. OTHER PEOPLE'S ATTITUDES ARE CRUCIAL

*"It is not the diagnosis of a mental health issue that leads to stigmatisation and consequently to social exclusion. Rather it is the manifestation of societal ignorance and fear about mental health issues that produce these outcomes. Stigma and social exclusion are fed by anxious, insecure, and prejudiced communities which do not tolerate difference."*⁴⁴

The consequences of mental illness, including discrimination and stigma, can be just as debilitating (or more so) than the illness itself,⁴⁵ Further, they add to the longevity of disablement and disadvantage.

In the Waikato University Mental Health Narratives Project, just as the support of others was the most commonly identified factor in facilitating recovery, it was the attitudes and behaviour of other people which were far and away the most common hindrance to recovery. What got in the way of recovery were other people's fears, their stigmatising behaviour, their lack of understanding, and their rejecting behaviour in relation to mental ill health.⁴⁶

Stigma and discrimination work directly against recovery, as they directly lead to and reinforce social exclusion at both an individual and systemic level. In one study, the researchers found that more than one third of employers believed people with a psychiatric disability to be violent or stupid.⁴⁷ Frost and colleagues conclude that employers' reluctance to hire people known to have a mental illness is likely to be due to a lack of understanding,⁴⁸ while Graffam and colleagues cite several studies showing that previous positive work-related experiences make employers more positive towards hiring people with disabilities.⁴⁹ In other words, once the mythology based on assumptions and stereotypes is broken down by exposure to someone with mental illness, attitudes do change. From changed attitudes comes inclusion, which leads to further changed attitudes, and so on.

Combating negative stereotypes and attitudes remains one of the most crucial aspects of promoting mental health for all people.

Better engagement and social inclusion of people living with mental illness will both help this process and be helped by it. The next sections deal with some of the practical aspects of social inclusion, meaningful employment and secure housing.

“Stigma and discrimination work directly against recovery, as they directly lead to and reinforce social exclusion at both an individual and systemic level”

⁴⁴ Mind (2003), op. cit., p. 5

⁴⁵ Anthony W (2000), op. cit., p. 160; Boardman I (2004), *Mental health and the politics of the white picket fence*, speech at Public Advocate's Mental Health Forum, Brisbane, June 2004

⁴⁶ Lapsley et al. (2002), op. cit., p. 86

⁴⁷ Graffam J and Naccarella L (1994), *National Evaluation Project*, Commonwealth Department of Human Services and Health, Canberra.

⁴⁸ Frost B, Carr V, and Halpin S (2002), *Employment and Psychosis: Low Prevalence Disorder Component of the National Study of Mental Health and Wellbeing, Bulletin 3*, Commonwealth Department of Health and Ageing, Canberra

⁴⁹ Graffam J, Smith K, and Hardcastle L (2005), *Achieving Substantive Equality and Optimal Participation: Employees with a Disability in the Victorian Public Sector: Report prepared for the Office of Public Employment*, Deakin University, Victoria

What is the evidence

The Importance of Community

MEANINGFUL CONNECTION IN COMMUNITY⁵⁰

If we consider what full social inclusion means in practice, we as a society need to fully embrace and include people with mental illness. This is not just the role of people with mental illness, their families, and mental health services: the community as a whole needs to actively and systematically include. This means a breaking down of the concept of seeing people living with mental illness as a homogenised group that is “different” or “other”.

This idea was clearly illustrated in the 1985 book by Nora Ellen Groce, *Everyone here spoke sign language*, a publication regularly used by disability advocates as an example of this absence of “otherness” in society. In the community it describes, Martha’s Vineyard, a high proportion of the people were deaf.

When the author asked what people thought of the deaf people, a resident responded with surprise: “they didn’t think anything about them, they were just like everyone else”, and when asked how people communicated with them, he said “you see, everyone here spoke sign language”.⁵¹

Full integration with the community was possible because everyone was familiar and comfortable with deafness, and the whole community took on the language that enabled easy communication. The story shows that a society can adjust to disabled individuals, rather than requiring those individuals to do all the adjusting.

So can this work with mental illness? Part of this is about changing community attitudes, for example via media campaigns to reduce stigma and myths around mental illness. But just as important is the process of individuals and communities reaching out to those living with mental illness. There are several good programs in operation internationally that seek to achieve this aim through individual connections. Perhaps the best known is Compeer, where volunteers are matched with a person with mental illness, and spend time each week undertaking recreational activities together. In Australia, the St Vincent de Paul Society runs the program in four locations. Its most recent evaluation has found that over 90% of respondents reported that the referred person felt less isolated, more cared about and had improved self esteem as a result of participating in the Compeer Program.⁵²

The “A Place to Belong” program in Brisbane uses the strategy of “asking” to link consumers with members of the broader community who share interests, lifestyles, or hobbies that interest the consumer. The agency identifies the kind of person the consumer would like to befriend, then goes into the community in search of someone with those characteristics, who is then “asked” to include the consumer in some of

⁵⁰ This section draws upon work done by Kaiyu Enterprises Inc. (Newcastle) outlined in Jackson, M (2007), *Community Inclusion / Community Recovery: Firm Theories to Tentative Practice*, presentation to the NSW NGO Conference, Sydney Masonic Centre, 1-2 March 2007.

⁵¹ Groce, N (1985) *Everyone here spoke sign language: Hereditary Deafness on Martha’s Vineyard*, Harvard University Press, Cambridge MA, p. 4

⁵² Accessed online at <http://www.vinnies.org.au/services.cfm?parentid=2&id=4>

their activities each week. This program has the dual aims of increasing consumers' social networks and increasing the knowledge of mental illness among members of the broader community who may not necessarily volunteer for this kind of role.

Psychotherapist David Schwartz suggests that although it is essential to have social services, one of the effects of this has been a decrease in freely-given relationships provided to those in need. There is an expectation in the community that there are services and systems designed to look after people, so there is less need for individuals to give help. This is important in the context of mental health when we are talking about the need for social inclusion and social connectedness. Even with all the best services, there is still a need for intimacy, relationships, and social connection, and in fact, Schwartz argues that it is those neighbourly, informal connections rooted in community that are the most effective forms of caring.⁵³

NGOs and community organisations can enable social inclusion aims through their work. Although they cannot do this alone, it is useful for governments and services to keep these aims and concepts in mind when planning and implementing programs to improve mental health. Carling's "six steps for social integration" helps to provide a practical framework to bring the idea of community integration together with service delivery:

1. Increase consumers' opportunities for social relationships;
2. Increase support for social integration;
3. Increase diversity of social connections;
4. Improve continuity of relationships;
5. Expand the number of freely given relationships; and
6. Increase chances for intimacy.⁵⁴

These steps are part of community development and creating places where people can come together. However, it is not as simple as just placing people together and expecting them to connect. Support and preparation is needed, and NGOs, peer support networks, and other community based groups and agencies are ideally placed to provide this to achieve quality social integration.

Importantly, these are all things that services can do, they are all things that consumers can do to help each other, and they are all things that any member of the community can do.

One final concept worthy of brief consideration here is the idea that communities themselves can and should "recover". Academic Jackie Goldstein suggests: "I believe that communities must also 'recover' in that they must learn to live WITH the realities of mental illness. ... The four stages of recovery [are]: hope, empowerment, self-responsibility, and a meaningful role in life. I believe that, for communities to recover, they too must be given HOPE that they CAN live WITH mental illness."⁵⁵

“communities must also ‘recover’ in that they must learn to live with the realities of mental illness”

⁵³ Schwartz, D (1997) *Who Cares? Rediscovering Community*, Westview, Colorado

⁵⁴ Carling, R (1995) *Return to Community: Building Support Systems for People with Psychiatric Disabilities*, The Guildford Press, New York

⁵⁵ Goldstein, J (2003), paper presented at Eighth Annual Conference of National Association of County Behavioral Health Directors Milwaukee, WI - Hyatt Regency Milwaukee July 11, 2003

We can acknowledge the central importance of each consumer's individual journey, but this does not mean that the consumer bears sole responsibility for this, nor does it mean that s/he has to adapt to fit in with the community. Everybody has a part to play, both individually in the connections we form, and collectively as a society to adapt where we can to accommodate and include difference in the promotion of mental health and living with mental illness.

FAMILIES AND CARERS

A social inclusion approach also includes supporting carers, those family members or friends who provide an enormous proportion of the care for people living in the community with a mental illness. One study shows that carers in Australia contribute an average of more than 100 hours per week caring for a person with a mental illness.⁵⁶ Providing this care can place a considerable strain on families and carers, whose own needs are often overlooked.

“People rarely choose to become carers, and are often thrown in at the deep end, with little or no formal training in dealing with mental illness.”⁵⁷ The benefits of providing support for carers are far-reaching – not just to the carers but to the consumer, family, and others involved in service delivery. Specific services and programs include: information and education about mental illness, training and education to help manage the caring role, education in coping skills and resilience, peer support to link carers with other carers, help with navigating the mental health system, respite, counselling, financial support, advocacy, carer support workers or staff in the mental health system, and programs for people with special needs (eg cultural, age-related).⁵⁸

When a family is confronted with the realisation that a son or daughter, partner, or other family member, has a mental illness, it is the time that families need a careful and sensitive introduction to what mental illness is, and what it is not. They need education in the language of mental illness, and they need to know what can be done, by whom, when and where.

It is clear to see that looking after carers contributes to better health outcomes for the consumers they care for. Further, carers themselves need care to reduce their risk of developing their own mental health problems. Carer and family support remains a crucial part of quality community-based care provided by NGOs.

The greater challenge is developing communities and environments that contribute to mental health for all. A more easily achievable imperative is to ensure there is a comprehensive, accessible and adequately resourced network of services available for people recovering from mental illness and their carers in the community.

“People rarely choose to become carers, and are often thrown in at the deep end, with little or no formal training in dealing with mental illness”

⁵⁶ ARAFMI NSW (2005), *Carer Services Mapping Project Final Report*, report prepared for NSW Department of Health, p. 10

⁵⁷ *Ibid.*, p. 6

⁵⁸ *Ibid.*, pp. 12-13

PEER SUPPORT AND CONSUMER NETWORKS

There are a number of support strategies that enable consumers to work together and access support from other consumers in the recovery process. These include self help and mutual support groups, telephone support lines, clubhouses and drop-in centres, policy advocacy and consumer networks, and various self help resources such as websites and information services.⁵⁹ Similar strategies also exist for carers and families.⁶⁰

A key proponent of the positive value of peer support for recovery from mental illness is Shery Mead. She defines peer support as “a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful”⁶¹ The peer support relationship is based upon a shared or mutual experience, and provides a space to connect with others through sharing knowledge, thoughts, and insights. As the relationship develops, a sense of trust is established, and the participants can feel safe to challenge their ways of conceptualising their own experience. In this way, recovery from mental illness incorporates a transformative aspect, offering hope and new meanings, and allowing for “new ways of thinking, doing, and living”.⁶²

It can be argued that social and peer networks that operate amongst people living with mental illness do not encourage inclusion in the broader community. However, as previously stated, everybody’s recovery process is different, and a number of interventions and supports may be needed to contribute to each person’s recovery.

Peer support as an approach is widely used to aid coping and recovery in a number of clinical areas, including cancer and diabetes, and is readily applied and sustained.

Empirical evidence supporting the effectiveness of these programs, particularly in Australia, is sparse, and such models do not easily lend themselves to the processes of conducting research studies. However, there is a vast number of such programs operating, many of which are supported by NGOs, and their close alignment with recovery principles, as well as favourable participant feedback, supports their use as part of a holistic mental health system.

Two recent publications have shown clear benefits from peer support. A study in the USA surveyed 1,824 people living with mental illness about their experiences with peer support programs. The study concluded that participation in peer support showed a significant association with improved recovery and sense of empowerment.⁶³ A South Korean study of people with co-occurring mental health and substance abuse problems compared hospitalisation rates for consumers participating in peer support

⁵⁹ A summary of the models can be found in Penrose-Wall and Bateman, op. cit.: support groups p 28; clubhouses and centre-based models p. 47; websites and information services p. 37; consumer networks p. 54.

⁶⁰ See Penrose-Wall and Bateman, op. cit., for a discussion around the practice models and NGO programs.

⁶¹ Mead, S (2003) *Defining Peer Support*, accessed at www.mentalhealthpeers.com/pdfs/DefiningPeerSupport.pdf, on 8 May 2007

⁶² Ibid.

⁶³ Corrigan, P (2006), Impact of consumer-operated services on empowerment and recovery of people with psychiatric disabilities, *Psychiatric Services* 57(10): 1493-6

“A ‘whole person’ approach is required, with both direct interventions and indirect determinants of mental health making contributions to people’s overall sense of mental wellbeing and capacity to function socially.”

program The Friends Connection, compared with a control group, and found that significantly fewer participants in The Friends Connection were hospitalised within a three year period.⁶⁴

A further study showed reduced re-hospitalisation among people re-entering the community under a Transitional Discharge Model, which had peer support as one of its core components.⁶⁵

Considerable descriptive and anecdotal evidence describes positive outcomes for consumers from peer support. As Rickwood describes, the most important aspect of peer support, particularly in the form of self help groups, is that they provide social contact and fellowship, and help break down the isolation that mental illness can cause.⁶⁶ She cites a 2003 study showing a positive effect on social networks as a result of participation in self help groups.⁶⁷

Further to this, peer support enables people recovering from mental illness to help others, which can contribute to their re-establishment of identity, and sense of worth and agency.

As a further indication of the recognition of the value of peer support, across Australia, community mental health services are increasingly employing consumers into paid positions where they can provide peer support.

Supporting peer support activities is an essential, and growing, part of NGOs’ activities in Australia. In its Social Inclusion Action Plan, the South Australian Social Inclusion Board advocates for ensuring there is enough capacity within NGOs to continue to support these activities.⁶⁸

ACCESS TO COMMUNITY-BASED SERVICES

A recent overview of the available evidence has shown that the models of assistance provided by the community sector in NSW have are effective and should be further supported.⁶⁹

Community-based agencies, primarily non-government organisations (NGOs) provide a number of psychosocial rehabilitation services. Psychosocial rehabilitation is a therapeutic approach that encourages the person living with mental illness to develop his or her fullest capacities through learning and environmental supports.⁷⁰ Its focus on treating the consequences of mental illness (disability and impairment) rather than just

64 Min, S, Whitecraft, J, Rothbard, A, and Salzer, M (2007), Peer support for persons with co-occurring disorders and community tenure: a survival analysis, *Psychiatric Rehabilitation Journal* 30(3): 207-13

65 Forchuk, C, Reynolds, W, Sharkey, S, Martin, M, and Jensen, E (2007), Transitional discharge based on therapeutic relationships: state of the art, *Archives of Psychiatric Nursing*, 21(2): 80-6

66 Rickman (op. cit.), p. 23

67 Hardiman and Segal (2003), cited in Rickwood, op. cit. p. 23

68 SA Social Inclusion Board, op. cit. p. 51

69 Penrose-Wall J and Bateman J (2006) *Working on strengths... the evidence so far: models of assistance by mental health community organisations and evidence of their effectiveness*, Mental Health Coordinating Council, Sydney

70 Bachrach L (1996), Psychosocial rehabilitation and psychiatry: What are the boundaries? *Canadian Journal of Psychiatry* 41(1):28-35.

the illness per se is an acknowledgement of the total impact of mental illness. “People with mental illness may have to recover from the stigma they have incorporated into their very being; from the iatrogenic effects of treatment settings; from lack of recent opportunities for self-determination; from the negative side effects of unemployment; and from crushed dreams. Recovery is often a complex, time-consuming process.”⁷¹

It is important that all aspects of community based care are taken into account, and it is not easy to separate the different contributions of different kinds of direct and indirect support for people in recovery.

In its discussion of what constitutes successful housing placements in the community, the Australian Housing and Urban Research Institute states: “participants were asked about what supports them to stay housed. It became evident that questions that simply and directly tied ‘supports’ to an outcome of ‘stable housing’ created some confusion The link between ‘staying housed’ and the various forms, levels and sources of support is conceptually very broad. These links can be *directly* associated with housing support, such as practical assistance with paying rent, activities of daily living and household tasks; or *indirectly* to more intangible factors that can improve a person’s mental health and emotional well-being, for example:

- social and community connectedness;
- stable and supportive environments;
- leisure and physical activities;
- access to social and supportive relationship;
- physical security;
- opportunity for self-determination and control over one’s life;
- access to work or meaningful engagement; and
- access to money.

Support that is not directly linked to housing needs can support a person to cope with the day to day demands of life generally. In turn, this makes it more likely that people can sustain housing.⁷² The same applies to other forms of support, such as employment and help with social functioning.

In other words, a ‘whole person’ approach is required, with both direct interventions and indirect determinants of mental health making contributions to people’s overall sense of mental wellbeing and capacity to function socially.

“[NGOs’] focus on treating the consequences of mental illness (disability and handicap) rather than just the illness per se is an acknowledgement of the total impact of mental illness”

⁷¹ Anthony (1993), op. cit.

⁷² O’Brien et al. (2002) op. cit., p. 39

ACCESS TO CLINICAL SERVICES

It is unhelpful to consider the acute hospital setting and the community setting as mutually exclusive, and it is almost universally acknowledged in the literature that consumers in recovery require ongoing access to clinical services. While some consumers require long term clinical support, others may only need episodic clinical care during times of ill-health. Some clinical services can be delivered in the community by GPs, psychiatrists, and community mental health services, while others may need to be delivered in the acute hospital setting.

The World Health Organization suggests that there is no longer any need for psychiatric hospitals at all. Instead, it advocates that the “extremely small proportion” of patients requiring long term care should be accommodated in “small units in the community, with an approximation to community living as far as possible”.⁷³ However, the majority of Western countries continue to maintain the necessity for a comprehensive inpatient service system complemented by community based services.

Thornicroft and Tansella, in an overview of systematic evidence around mental health care, suggest a “pragmatic mix” of hospital and community services is required, with the relative proportion of each being quite different for each person.⁷⁴ Access to clinical services needs to be a part of the overall network of services available to each person. And like those services in the community, they need to be responsive and accessible, with clear links and follow-up back to the community. So, rather than a dichotomy, we have a network.

And like anybody else living in the community, the consumer has access to social and recreational activities; health and other services; and family, friends and neighbours. Applying the principles and practices of social inclusion in combination with an effective network of community-based services would see them decrease reliance on such services over time as their skills, functioning, networks and resilience improve.

“While some consumers require long term clinical support, others may only need episodic clinical care during times of ill-health”

⁷³ World Health Organization (2003), op. cit., p. 33

⁷⁴ Thornicroft G and Tansella M (2004), Components of a modern mental health service: a pragmatic balance of community and hospital care: overview of the systematic evidence, *British Journal of Psychiatry*; 185:283-90



The diagram shows that there are a number of components of recovery and services available to the consumer, including the hospital, which s/he may access at different times according to individual need.

There is an identified current problem in Australia of de-institutionalisation inadequately backed up with community resources, as well as an ill-informed and prejudiced public. When discharged to the community in this context, consumers can find themselves in conditions comparable to those in institutions, either literally (in prison or sub-standard housing) or figuratively – including isolation, discrimination and hopelessness for the future. Additional problems including long term unemployment, poor housing, poverty, and poor functioning, lead to deteriorating mental health.⁷⁵ When combined with other forms of disadvantage, such as minority ethnic communities, sole parents, older people, and ex-prisoners, the problems are escalated.

⁷⁵ Mind (2003), op. cit.

SOCIAL EXCLUSION COMPOUNDED

We have discussed the social exclusion that may characterise the experience of living with mental illness. However, for those people living with mental illness who may also belong to a community that is already socially excluded within our society, there is a compounded effect of social exclusion. Such communities include (but are by no means limited to) Indigenous Australians, people from culturally and linguistically diverse backgrounds,⁷⁶ people in the criminal justice system and forensic patients,⁷⁷ the homeless, people with physical or intellectual disabilities, and many other socially disempowered groups.

There is not the scope within this document to go into detail about these compounded effects, except to acknowledge the added burden of exclusion faced by these people, and to stress the importance of both systemic and individual approaches to promoting social inclusion for all.

76 For a good discussion, see Multicultural Disability Advocacy Association of NSW (2007) *Social Inclusion: Its importance for people from non-English speaking backgrounds with mental illness*

77 For a good discussion of the many issues surrounding mental illness and the justice system, see www.justiceaction.org.au

The Importance of Secure Housing

“Housing is one of the critical factors in a person’s recovery process. A wealth of empirical evidence now attests to the fact that poor, unsuitable, substandard, and / or unaffordable housing has a direct impact on the emotional and social wellbeing of mental health consumers. Simply put, good mental health requires good housing”

Office of the Public Advocate – Queensland (2005) Submission to the Senate Select Committee Inquiry into Australian Mental Health Services, p. 11

It has long been established in public health literature that appropriate, stable and secure shelter is fundamental to health and wellbeing. Only more recently has this been extended to those living with mental illness. Stable housing provides a “base from which a person can focus on their recovery”,⁷⁸ and effectively operates as a foundation upon which improved determinants of mental health become more accessible. Where housing is stable, it can be taken for granted or not explicitly considered when people think about what supports them.

“A lack of appropriate supported accommodation is the most significant obstacle to effective recovery and rehabilitation for people living with mental illness.”

A lack of secure housing forms part of the picture of a weakened social network, family breakdown, and lack of community participation. Living alone, in poverty, or being homeless, have all been shown to have a negative effect on mental health. Sadly, these are common outcomes for people discharged from institutions into an unsupportive and alienating society. This leaves people vulnerable to neglect, abuse, homelessness, and the ‘revolving door syndrome’, where they enter cycles of admission, discharge, and re-admission to hospital. Clearly, this is not a conducive context for recovery.

The Human Rights and Equal Opportunity Commission (HREOC) states that a lack of appropriate supported accommodation is the most significant obstacle to effective recovery and rehabilitation for people living with mental illness.⁷⁹

At different stages of their illness and recovery, people with mental illness need quite varying levels of support. While in the early post-acute stage, 24-hour care may be required for some people, but for people in recovery, secure independent accommodation with weekly or as-needed support is more effective in promoting improved mental health. Needs will also differ according to age, gender, cultural background, and individual circumstances. An additional range of support is required for those with co-existing alcohol or other drug problems.⁸⁰

⁷⁸ Rickwood (2006) op. cit., p. 36

⁷⁹ Human Rights and Equal Opportunity Commission (1993), *Human Rights and Mental Illness*, Australian Government Publishing Service, Canberra (‘the Burdekin Report’)

⁸⁰ See Rickwood (2006), op. cit., p. 36, for further details of specific needs.

WHAT IMPEDES INDIVIDUALS' ABILITY TO MAINTAIN INDEPENDENT LIVING?

The Australian Housing and Urban Research Institute (AHURI)⁸¹ has identified the following behaviours that some people living with mental illness and its related disabilities may experience, which makes it more challenging to maintain tenure in accommodation without support:

- Inability to perform routine tasks, such as dressing, cooking, or paying bills;
- Persistent feelings of high anxiety leading to difficulties in leaving the house without assistance, with fear of panic attacks making it difficult to use public transport or to shop;
- Extreme mood swings, from depression and sadness to elation and excitement;
- Delusions, such as feelings of persecution, which may create difficulties with neighbours;
- Hallucinations, which can distort one's senses, creating fear, confusion and unreal beliefs;
- Thought disorder, which means that speech may be jumbled and difficult to follow;
- Aggressive behaviours towards others, that can arise from fear, unreal thoughts, frustration or influences of substance abuse.

These may fluctuate, meaning people's capacity to function effectively can vary considerably at different times. They may also be exacerbated by the co-existence of experiences of isolation, inadequate support, and stigma and discrimination.

Again, a lack of understanding of mental illness among neighbours, fuelled by misconceptions and stereotypes, can add to social isolation, which, among other things, puts a strain on tenancy maintenance.

WHAT IS THE EVIDENCE?

Clear benefits have been shown through the comparison of supported accommodation in the community with institutional care for consumers in recovery. The World Health Organization summarises the findings from a series of studies throughout developed countries, as follows:

- 73% of studies found significantly better outcomes in functioning, and psychosocial adjustment;
- 64% of studies found significant reductions in hospital admissions / re-admissions;
- 64% of studies found significant increase in patient satisfaction.⁸²

81 O'Brien A, Inglis S, Herbert T, and Reynolds A (2002) *Linkages between housing and support: what is important from the perspective of people living with a mental illness*, Australian Housing and Urban Research Institute (AHURI), Swinburne/ Monash Research Centre / Ecumenical Housing Inc.

82 World Health Organization (2003), *Organization of Services for Mental Health: Mental Health policy and service guidance package*, WHO, p. 46

This body of research continues to grow, and there is consistent evidence highlighting the importance of stable accommodation and ongoing support in the long-term recovery of people with mental health issues.⁸³ A recent Cochrane Review has called for more randomised trials that compare supported housing with other forms of community-based living,⁸⁴ although they acknowledge the complexity of such interventions.

Internationally, there is also a growing number of programs showing clear and tangible benefits for people receiving quality supported housing in the community. For example, in NSW, significant improvements in clients' quality of life, community participation and mental health have been demonstrated by the Housing and Accommodation Support Initiative (HASI).

The HASI program, a partnership between the Housing and Health departments and NSW NGOs, provides high-level supported accommodation in the community for people with a range of support needs. A network of agencies (mainly NGOs) provide a range of services to meet the clients' needs in the community.

The program has a recovery focus and provides permanent housing and long term flexible support in recognition that the frequency of recurring episodes or ongoing levels of psychiatric symptoms and disability varies considerably between individuals.

The early evaluation findings included:

- 66% of clients reported improved mental health;
- two thirds of clients had improved psychological functioning, with the average score moving from 38 ("serious impairment") to 65 ("generally functioning pretty well");
- almost half the clients with a substance use disorder were no longer experiencing substance use problems; and
- on average, all clients increased their independence in living skills.⁸⁵

Importantly, the program is indicating more than 70% decrease in demand for acute hospital admissions, and the 'revolving door' phenomenon has all but disappeared.⁸⁶

“The HASI program in NSW has seen improvements in mental health, functioning, and independence, and decreased substance abuse”

⁸³ Browne G and Courtney M (2005), Housing, social support and people with schizophrenia: A grounded theory study, *Issues in Mental Health Nursing*, 26(3), 311-326; Browne G and Courtney M (2004), Measuring the impact of housing on people with schizophrenia, *Nursing Health Science*: 6(1):37-44; Freeman A, Malone J, and Hunt G (2004), A statewide survey of high-support services for people with chronic mental illness: Assessment of needs for care, level of functioning and satisfaction, *Australian and New Zealand Journal of Psychiatry*, 38:811-18; Rog D (2004), The evidence on supported housing, *Psychiatric Rehabilitation Journal*, 27(4):334-44; Tsemberis S and Eisenberg R (2000), Pathways to housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities, *Psychiatric Services* 51(4):487-93.

⁸⁴ Chilvers R, Macdonald G, and Hayes A (2006), *Supported housing for people with severe mental disorders (Review)*, The Cochrane Collaboration

⁸⁵ Social Policy Research Centre (2006), op. cit.

⁸⁶ Ibid.

One staff member explained the change in one of her clients: “Twelve months ago [he] had no idea about how to keep his house clean and tidy ... he’s gone from full dependency to only two hours of support a week. He now recognises his house needs cleaning, which for him is amazing’.

Clients too recognised their increased independence. One client said: ‘I’m more independent now. I’m shopping on my own [and] I do my own cooking’, while another reported: ‘I’ve got a lot of independence now. ... I go to the doctors by myself, I did the computer course on my own ... [and] I might go and meet my friend at the club or go out elsewhere’.⁸⁷

THE NEED FOR A MULTI-AGENCY APPROACH

AHURI has identified the need for a multi-sector, sustained approach to community based care. Establishing people in stable accommodation is not a solution on its own, and they cite consumers who have had stable accommodation in the past, before experiencing episodes of homelessness and instability. “What is needed is a system of accommodation, support, and mental health care with the capacity to form ongoing relationships with clients, and to respond to the destructive experiences layered under presenting disadvantage and distress”.⁸⁸

A 2002 Victorian study undertaken with people living with mental illness with successful tenancies, examined the factors that contribute to successful maintenance of tenancy. The study concluded:

*It was evident that key supports were vital – from a stable income, to appropriate treatment, to psycho-social rehabilitation. Such supports have helped participants to develop their own readiness to live independently. Support that was tailored to particular individual needs and aspirations, and to the way in which the mental illness manifested was also important.*⁸⁹

There is a crucial role here for local networks of NGOs to provide key services that meet the needs of consumers and their carers based in the community.

⁸⁷ Ibid., p. 15

⁸⁸ Robinson C (2003), *Understanding iterative homelessness: the case of people with mental disorders*, Australian Housing and Urban Research Institute, UNSW/UWS Research Centre, p. 43

⁸⁹ O’Brien et al. (2002), op. cit., p. 58

“The link between support and sustainable housing is [often found] in the help that reinforces and assists people to cope with the challenges of daily living and often gradually increases their ability to live independently.”

WHAT DO PEOPLE WANT?

People with mental illness consistently say they want to live in ‘normal’, home-like environments. A number of studies examining consumers’ preferences for housing have found that consumers highly value:

- independence and choice;
- convenient location;
- safety and comfort;
- affordability;
- privacy; and
- social opportunity.⁹⁰

This is uncannily similar to preferences of most people in the broader Western community.

People with mental illness also value practical skills development, material aid and emotional support to help them to achieve independence, especially when they have fluctuating periods of illness and/or disability. The link between support and sustainable housing is not always found in tangible assistance with housing matters, but in the help that reinforces and assists people to cope with the challenges of daily living and often gradually increases their ability to live independently.

This support requires a network of services that can respond to each individual’s changing needs, and goes beyond the scope of Government’s health and housing interventions. This will be further explored in the following sections.

90 Ibid.

The Importance of Employment

*Unemployment is a health hazard for general populations, but is particularly hazardous for people with a psychiatric disability, contributing to lower self esteem; higher levels of psychiatric disturbance; severe social isolation; stigmatisation; and further marginalisation within society”.*⁹¹

It is in the area of employment that there is the most compelling evidence linking social inclusiveness with improved mental health and recovery from mental illness.

It is well established that employment is strongly associated with positive mental health, including higher self esteem and sense of agency and purpose, and that unemployment degrades sense of purpose, structure, social status and sense of identity.⁹² Studies have associated employment with reduced psychiatric symptoms, higher functioning, an improved sense of self worth, and a significant improvement in social skills.⁹³ Being employed enables social inclusion in the wider community and “represents an important way people with mental illness can meaningfully participate in society.”⁹⁴

Importantly, employment is a basic human right, identified in the various human rights instruments, including the Declaration on the Rights of Disabled Persons. Article 7 states: “Disabled persons ... have the right, according to their capabilities, to secure and retain employment or to engage in a useful, productive, and remunerative occupation”.

Notwithstanding this, everybody’s recovery journey is different, and employment is not an option for all consumers. However, the outcomes of increased sense of purpose and social inclusion are still important for those not in paid employment to enable them to have the best opportunity for rehabilitation and recovery.

Having a job can facilitate recovery, but having a job is not essential to the recovery process. Many people gain similar satisfaction, self-esteem and purpose in life from other life activities⁹⁵ and forms of social engagement such as parenthood, study, art, caring for family members, or volunteering.

Education, and participation in recreational, leisure, and/or work-readiness programs, have all been shown to contribute to improved self esteem and quality of life.

91 Rose V and Harris E (2005), What employment programs should health services invest in for people with a psychiatric disability? *Australian Health Review* 29(2): 185-88

92 Waghorn and Lloyd (2005), op. cit., Boardman J (2003), Work, employment and psychiatric disability, *Advances in Psychiatric treatment* 9: 327-34

93 Frost et al (2002), op. cit., p 2.

94 Waghorn and Lloyd (2005), op. cit., p. 4

95 Shaheen G, Williams F, and Dennis D, eds (2003) *Work as a Priority: a resource for employing people who have a serious mental illness and who are homeless*, US Department of Health and Human Services

CAPACITY AND DESIRE FOR WORK

The high unemployment rate among people with serious mental illness is not an indicator of a lack of capacity to work or a lack of desire to work. People with mental illness face a number of potential barriers to engaging in work, including:

- Stigma, ignorance, misunderstanding, and discrimination can make employers reluctant to hire;
- Fear of failure in the workplace, sometimes accompanied by fear of subsequent loss of entitlements such as pensions or allowances; and
- Lack of workplaces that are flexible or accommodating to the needs associated with episodic illness.⁹⁶

Most people living with mental illness and mental health problems want to work, and consider it to be a feasible and desirable part of their recovery.⁹⁷

As illustrated in the previous section, many people do recover, and even those who have experienced the most severe forms of schizophrenia can achieve successful employment outcomes with the right support.⁹⁸

WHAT IS THE EVIDENCE?

There are two main approaches that NGOs and other community-based agencies provide for people living with mental illness, and each has its own purpose and appropriate target group.⁹⁹ Open Employment (termed “supported employment” in the US and much of the literature) refers to assistance provided to help consumers obtain and retain employment on the competitive job market. Supported Employment (also known as “transitional employment” or “vocational rehabilitation”) covers a range of models providing high support and skills training, usually in a non-competitive work setting.¹⁰⁰

Regardless of the model, having some form of direct support for individuals has been shown to significantly improve the rates of obtaining and retaining work. For many, this in turn has been shown to be a key component of successful social engagement and recovery.

Open employment in particular has a strong evidence base, and to date its success has been supported by several randomised controlled trials and other studies comparing it to other approaches to seeking employment.¹⁰¹

“Direct support for individuals has been shown to significantly improve the rates of obtaining and retaining work.

This in turn can be a key component of successful social engagement and recovery.”

⁹⁶ Ibid, p. 11

⁹⁷ Waghorn and Lloyd (2005), op. cit., p. 15; Mind (2003) *Mental Health and social exclusion: the Mind response*, London, p. 7

⁹⁸ Waghorn and Lloyd (2005), op. cit., p. 14

⁹⁹ Penrose-Wall and Bateman (2006), op. cit., pp. 21-25

¹⁰⁰ See Waghorn and Lloyd (2005), op. cit., p. 5-6 for a more detailed explanation.

¹⁰¹ Bond et al. (2001), op. cit.

Based on findings of four studies and nine randomised controlled trials on open employment in the USA, Bond found that 40% - 60% of consumers obtained competitive employment compared with less than 20% of those who were not in such a program. He further found that consumers who retained competitive employment for a sustained period demonstrated benefits such as improved self esteem and control of symptoms.¹⁰²

Another study, looking at the 10-year outcomes of clients who participated in supported employment in the early 1990s, found that the benefits of supported employment lasted for the longer term, with participants reporting successful competitive employment and substantial improvements in self esteem, hope, relationships, and control of substance abuse.¹⁰³

A 2004 UK study found there was no strong correlation between consumers' psychiatric diagnosis and their work performance, and many consumers performed better than had been expected. The reasons for this were attributed to consumers' gains in confidence, motivation, and self belief.¹⁰⁴

For those consumers for whom open employment is not an option, support in acquiring social skills and other basic work skills can be achieved through transitional or sheltered employment. Such opportunities can help with developing self esteem and personal growth.¹⁰⁵

WHAT HELPS PEOPLE GAIN EMPLOYMENT?

Shaheen and colleagues, with reference to a number of other studies, identify the following factors that contribute to successful employment outcomes for people with mental illnesses:

- Employment services experienced as part of an overall integrated recovery plan;
- A consumer-driven approach, with emphasis on consumer preference and practical assistance with finding jobs;
- Ongoing assessment and support based on individual needs and preferences; and
- Services that understand the specific issues around work and mental illness, and that value the individual consumer driven approach.¹⁰⁶

The first point here is particularly relevant to this paper. Employment (or its equivalent for those unable to achieve employment) is one component of individual recovery, and as will be discussed later, each component needs to operate in an integrated manner. It operates alongside secure housing and other social support services in a whole person approach.

¹⁰² Bond (2004), op. cit.

¹⁰³ Salyers M, Becker D, Drake R, Torrey W, and Wyzik P (2004), A ten-year follow-up of a supported employment program, *Psychiatric Services* 55(3): 302-8

¹⁰⁴ Stepney P and Davis P (2004), Mental health, social inclusion and the green agenda: an evaluation of a land based rehabilitation project designed to promote occupational access and inclusion of service users in North Somerset, UK, *Social Work Health Care* 39(3-4): 375-97

¹⁰⁵ Waghorn and Lloyd (2005), op. cit., p. 16

¹⁰⁶ Shaheen et al. eds (2003), op. cit., p. 32

Frost and colleagues stress the importance of partnerships and networks, and cite the success of the Hunter Psychiatric Employment Panel, a partnership between NGOs, Government, and the community Mental Health Service. This was a consumer-focused program that directed individuals to the most appropriate services according to their individual needs. In its first two years, it had a success rate of 76.5%, placing consumers in a combination of open employment, work skills development, and mainstream educational services.¹⁰⁷

In the workplace itself, the factors that have been found to contribute to successful retention of employment among those recovering from mental illness are closely aligned with those factors that promote good mental health in the workplace for the whole community. These include: training and support, supportive interpersonal relationships, flexibility, workplace culture, and a management culture with a genuine interest in the employee's welfare.¹⁰⁸

Again, the importance of connection with others and feeling socially accepted and included lies at the heart of successful recovery journeys.

107 Frost et al, (2002), op. cit.

108 Secker J and Membrey H (2003), Promoting mental health through employment and developing healthy workplaces: The potential of natural supports at work, *Health Education Research*, 18(2): 207-15

Where are we now?

It is an interesting time for mental health service provision in Australia, with the unprecedented agreement in 2006 of the Council of Australian Governments (COAG) to focus on mental health as a priority in planning and funding, and the release of a number of policy documents relating to mental health and social inclusion. It is timely therefore, to bring together the evidence to present a clear picture of what we currently know about quality mental health care, to increase community awareness and to inform how this funding is directed.

Federal and State/Territory governments have pledged a combined commitment of \$4 billion for mental health over the next five years.

This includes a Federal Government commitment of \$1.8 billion over five years to boost the workforce, community-based services and a team-based approach incorporating psychiatrists, GPs, and allied health services, as well as respite for carers, and some new programs to improve community awareness.

Since that time, specific community-based programs have been developed including Care Coordination, Personal Helpers and Mentors, and the Support for Day to Day Living in the Community program. These are all in their early days, and have good potential to promote the principles of social inclusion if implemented well.

The NSW Government has committed \$939 million over the next 5 years to mental health programs, with increased funding to community mental health services with a focus on rehabilitation. Whilst only a small proportion of this funding is targeted to NGOs, this is an increase on previous funding commitments.

The NGO sector and other community-based services have been encouraged by the recognition that more resources are required in the community, including the need for the NGO sector to provide training and development opportunities for its workforce in line with current evidence based practice.

The National Action Plan on Mental Health, compiled jointly by Federal, State, and Territory governments in July 2006 emphasises coordination and collaboration between government, private and non-government providers, and aims to better support people with mental illness to participate in the community.¹⁰⁹

These are strong statements of commitment to a better resourced community-based approach to mental health care, and it remains a task for our sector and the government to see this through in the most effective manner.

In recognition of the importance of social inclusion and its cross-portfolio focus, the NSW Government has established the *New South Wales Interagency Action Plan*

¹⁰⁹ Council of Australian Governments (2006), *National Action Plan on Mental Health 2006-2011*, p. i

for *Better Mental Health* (2005).¹¹⁰ The Human Services CEOs' group (comprising the directors general of Health, Housing, DADHC, DOCS, Education, and Juvenile Justice) has responsibility for overseeing progress against this Plan, which is an acknowledgement of the cross-portfolio responsibility for mental health services, as well as the whole-of-community responsibility for mental health and effective responses to mental illness that are conducive to recovery.

Another interesting model, which more directly acknowledges the importance of social inclusion, can be seen in South Australia, where a Social Inclusion Unit has been established. The Unit is accountable directly to the Premier, and has a broad-ranging agenda that takes in initiatives and priorities that are the responsibility of several government departments. This framework allows it to take a big picture approach not limited by the scope of one area of policy, and instead has a vision of a socially inclusive community at its core. In 2005, the Unit was given the responsibility of reforming the mental health system, in recognition that people living with mental illness are among the most socially excluded in our community.¹¹¹

There is great opportunity in the current political climate, with attention on mental health, to progress the strategic approach that is required to achieve social inclusion through better oriented services and a better educated community.

110 This can be accessed at http://cabinet.nsw.gov.au/__data/assets/pdf_file/129/interagency.pdf.

111 South Australian Social Inclusion Board, *Stepping Up: a social inclusion action plan for mental health reform 2007 – 2012*, p. 1.

So where to now for NGOs?

Social Inclusion provides a useful guiding framework under which NGOs can situate the work they undertake. Bringing concepts of social inclusion into practice and into the work of promoting mental health and managing mental illness remains a vital challenge for all working for mental health.

From a policy perspective, the social inclusion agenda can be seen as quite complex, requiring a cross-agency and whole-of-government approach. What this means in practice is that planning and implementing strategies to enhance social inclusion cannot be the sole responsibility of one agency or government department, and we need to think and plan across programs and jurisdictions. Across Australia we are seeing a growing interest and understanding of the importance of social inclusion for mental health, but there still remain challenges in identifying how to best implement strategies that will enhance social inclusion in practice.

So what does this mean now for our sector? It is an opportune time now to bring in what we know about the importance of social inclusion to the current reforms in mental health. There are roles here for both governments and NGOs.

The following principles should underpin the work of enhancing social inclusion through our work:

- a. Efforts to promote social inclusion are by definition complemented by efforts to decrease social exclusion. So we need to do things that promote social inclusion, as well as things that decrease social exclusion.
- b. Due to the community-based and community-centred nature of NGOs, the sector is well placed to encourage and allow social participation and inclusion across communities, and there is great value in governments providing sustained investment and support to the NGO sector to assist it to continue to do this.
- c. Services need to be consumer focused, have a whole-of-person approach, and respond to each individual's changing needs.
- d. Social inclusion requires a shared vision and operational partnerships among NGOs, government, and other services to enable a seamless and coordinated recovery journey for consumers.
- e. All agencies, regardless of their size and structure, can apply principles of social inclusion. Social inclusion can be a unifying goal across the sector. Differences and diversities of approach, rather than being seen as representing weakness or a lack of cohesion, in fact act to strengthen the capacity of the sector as a whole in the pursuit of this aim.
- f. As the peak body in NSW, MHCC has an important role to play in developing, training, and unifying the sector as a whole to build its capacity in relation to social inclusion.
- g. As a sector, we need to be able to demonstrate our impact in achieving outcomes including those related to social inclusion.
- h. Specific focus on those communities that are currently socially excluded is required.

Recommendations

SOCIAL INCLUSION

1. There is considerable evidence from different fields supporting the link between social inclusion and mental health. It is therefore imperative that the mental health care system is strongly grounded in principles and enablers of social inclusion.
2. Increased knowledge of the importance and the enablers of social inclusion is required throughout the broader community.
3. The government, non-government and business sectors should have a sound knowledge of the importance of social inclusion in community development.

DIVERSITY

4. Central to social inclusion is valuing difference and diversity within communities. Increased awareness of the value of difference and what it brings to communities is required.
5. All government and non-government mental health services staff should possess and apply to their work a high level of cultural competence and an appreciation of the value of diversity, to ensure that people are not excluded due to their difference or culturally diverse status.

ACROSS-GOVERNMENT APPROACH TO MENTAL HEALTH

6. The NSW Interagency Action Plan, describing a partnership approach between government departments and non-government organisations, should be brought to fruition and expanded to enable a wholistic approach to mental health care in NSW.

COMMUNITY ENGAGEMENT WITH POLICY

7. Policy developers must fully and genuinely engage with the community, including consumers, carers, families, and non-government organisations in planning and shaping policy affecting mental health care in NSW. The government must develop ways to enable community participation in a meaningful form rather than a token gesture.

LOCAL DELIVERY OF NATIONAL PRIORITIES

8. Whenever state or national policies and imperatives are developed, there must be flexibility in planning, implementation and funding structures to enable programs to be managed and delivered within local communities in a manner that is responsive to local needs and populations.

VALUING NON-GOVERNMENT ORGANISATIONS

9. Some of the key strengths of NGOs are that they are located and work within local communities; that they offer a choice of services; and that their differences in size, constitution, core business, and philosophies reflect the diversity of Australian communities.

10. A range of coordinated programs allowing people with mental health problems and their families and carers direct access to support from community-based mental health organisations is needed.
11. Governments, policy makers and communities should recognise the value of community-based approaches, and enable capacity development of the NGO sector in planning and resource allocation by means such as: workforce development, skills development, and promotion of partnerships.

PROMOTING RECOVERY

12. When planning and implementing services, all government and non-government staff should be informed by a recovery orientation that is focused on helping people with a mental illness to live satisfying, hopeful and contributing lives.
13. In all interactions with mental health consumers, whether in inpatient units or community-based services, all government and non-government staff should fully adopt and be informed by recovery principles including:
 - an individualised approach to each person's care,
 - respect for each person's expertise in and capacity to manage their own health;
 - a focus on the whole person focus, not just his/her symptoms;
 - involving the person and their carer/family into care planning and interventions; and
 - fostering trust and hope.
14. Recovery principles must inform all campaigns to combat stigma in the community, including the simple message that consumers do recover.
15. All Government departments (particularly Housing and Employment) should ensure that their front line staff who are likely to have contact with people living with mental illness are adequately trained in mental health, mental illness, recovery, and the complexity of issues facing people living with mental illness.
16. Continued and expanded support and resources should be provided to non-government agencies and other networks that facilitate consumer-run peer support programs based evidence-based methodologies, due to the wealth of evidence that such programs aid recovery.

STIGMA AND DISCRIMINATION

17. The broader community needs more education and increased engagement with people with mental illness to break down stigma and discrimination, to engage, and to include.

CONSUMER PARTICIPATION

18. All agencies and Government departments must ensure that consumers, carers, and families have meaningful input into planning and implementing programs and policies.

19. Agencies should, as part of their planning and professional development programs, provide support, encouragement, and training to consumers and carers to enable them to have meaningful participation.

EMPLOYMENT

20. Due to its comparative success in securing employment for people living with a disability, the Disability Employment Network should be retained as a distinct program, with disability-specific specialist services.
21. Employers need a greater awareness of the many benefits to society and to their business of promoting positive mental health and reducing negative stereotypes of mental illness within the workplace.

HOUSING

22. Adequate housing is a major part of achieving social inclusion, and many non-government organisations provide vital assistance to help clients maintain their housing. The NSW Government and NGOs should work together to develop new models of housing and support that adequately meet the needs of high need households, including those living with mental illness.
23. The NSW Government should redress the current system of offering 2, 5, or 10 year leases to public housing tenants to be more flexible where the tenant has an episodic illness such as many mental illnesses.

HOMELESSNESS

24. Better alignment of the homelessness and housing systems is needed to provide sustainable pathways out of homelessness and into secure housing.
25. Proven accommodation support models should be expanded to address the problems of homelessness (eg. "HASI for the homeless").

SOCIAL WELFARE

26. Several aspects of the Welfare to Work and WorkChoices legislation are disincentives to employment for people living with mental illness, and fail to take into account the episodic nature of many mental illnesses. Urgent changes are needed to this legislation to achieve a positive impact on social inclusion through employment.
27. The philosophy underlying the Welfare to Work legislation is one of compliance, and needs to be changed to a philosophy that facilitates and nurtures meaningful workforce participation, as is indicated by evidence-based good practice.

CRIMINAL JUSTICE SYSTEM

28. People with mental illness are over-represented in the criminal justice system. Implementation of a range of community-based programs to meet the complex needs of people who are or have been in contact with this system is urgently needed to break the cycle of mental illness, poverty, unemployment, and substance abuse.
29. People with mental health and/or substance abuse problems, when released from prison, suffer a social exclusion “double whammy”, and many initially have high needs in order to achieve a reasonable degree of social inclusion. More resources and programs to facilitate this process, such as supported accommodation, supported employment, social support and drug and alcohol programs, are urgently required.
30. Research is needed into alternative methods of rehabilitation and support for people with mental illness and/or co-morbidity (both with intellectual disability and/or with alcohol and other drugs) in the criminal justice system.
31. Consumer participation is an essential component of the development of social inclusion. All forensic facilities should include consumer participation to inform and enhance delivery of more efficient services to meet the complex needs of forensic consumers on both an individual and systemic level.

Conclusion

It is well established now that recovery occurs, and that it is linked with community engagement and social inclusion. The community setting, backed up with clinical care as required, is where recovery needs to occur.

The models of assistance provided by the NGO sector in NSW have been shown to be effective,¹¹² and the evidence base is growing for specific community-based interventions. It is in this sector that sustained investment and political focus is required. We do not view the COAG initiatives as an end in themselves; rather, they indicate a government impetus and focus on mental health that we hope is just the beginning of a sustained process that places *the individual living in the community* at the centre of the mental health system.

Importantly, the longer term imperative of governments, services, and communities should be to put into place those structures, frameworks, systems and so on that will enable the principles of social inclusion to be realised for the better mental health of all people. There are broad cross-society implications, including breaking down discrimination against those living with mental illness, as well as developing the capacity of individuals and communities to respond early and effectively when someone's mental health appears at risk.

In addition, our social environments have a strong impact. Internationally, there is an increased focus on the “determinants” of mental health, which are those things that impact on people's mental health and wellbeing. This relates closely to principles of social inclusion, and in promoting mental health, we need to also focus on reducing the preventable causes of mental health problems – “the mental health equivalents of smoking and car exhaust fumes”¹¹³ – such as poverty, family dysfunction, childhood abuse, unemployment, etc.¹¹⁴ This emphasises the role of the whole community in improving mental health.¹¹⁵ Again, the social inclusion approach offers a valuable framework to view both the individual and collective responsibility for good mental health.

112 Penrose-Wall and Bateman (2006), op. cit.

113 Friedli, L. (2005), Promoting mental health in the United Kingdom: a case study in many parts, *Australian e-Journal for the Advancement of Mental Health (AeJAMH)*, 4(2): p. 3

114 This is well articulated in Commonwealth Department of Health and Aged Care (2000), *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health*, Commonwealth of Australia, Canberra

115 See for example, the WHO Europe Helsinki Declaration which was signed in January 2005 at the WHO European ministerial conference on mental health, attended by all 52 countries in the European region of WHO. World Health Organization (2005) *Mental Health Declaration for Europe: Facing the Challenges, Building Solutions* (www.euro.who.int/document/mnh/edoc06.pdf); and World Health Organization (2005) *Mental Health Action Plan for Europe: Facing the Challenges, Building Solutions* (www.euro.who.int/document/mnh/edoc07.pdf).

Definitions

Carer: A person who, at time of need, provides regular or intermittent support to someone who has a mental illness or disorder. The carer may not necessarily be a family member, or live full time with the cared for person, but is one who has assumed the close, non-institutional caring role as a friend or advocate, and provides financial and/or emotional and/or practical support.¹

Community-based organisation/approach: An organisation or approach that arises from, and is driven and governed by communities within a community setting. This is as distinct from a Government-run organisation or a private for-profit organisation.²

Consumer: A person who is currently using, or has previously used, a mental health service.³

Mental health: A state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community⁴

Mental health problem: A disruption in the interaction between the individual, the group and the environment, producing a diminished state of mental health.³

Mental illness: A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities.³ Where this term is used throughout this document, it also includes people with a mental health problem.

Non-government organisation (NGO): Not-for-profit, community-managed organisations that provide community support services for people affected by mental illness. They provide psycho-social rehabilitation, promote self-help, and/or provide support and advocacy services for consumers, their families and carers.³

Outcome: A measurable change in the health of an individual, or group of people or population, which is attributable to interventions or services.³

Psychosocial Rehabilitation: Services with a primary focus on interventions to reduce functional impairments that limit the independence of people whose independence and physical/psychological functioning has been negatively impacted upon as a result of a mental illness. Psychosocial rehabilitation focuses on disability and the promotion of personal recovery, giving people the opportunity to work, live and enjoy a social life in the community. It is also characterised by an expectation of substantial improvement over the short to mid-term.³

Vocational Rehabilitation: Services with a primary focus on interventions to assist people who have experienced or continue to experience a mental illness to enter or re-enter the workforce and to sustain employment. Vocational rehabilitation focuses on prevocational preparation, vocational skills training, placement, support, and advocacy. People who use these services usually have a relatively stable pattern of clinical symptoms.³

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1. Association of Relatives and Friends of the Mentally Ill, 1999, cited in AFAFMI (2005) op. cit., p.10

2. Mental Health Coordinating Council

3. Australian Health Ministers (2003), *National Mental Health Plan 2003 – 2008*, Commonwealth of Australia, Canberra

4. World Health Organization (2001), *World Health Report*

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