

Introduction

The South Australian Mental Health Commission (the Commission) was established by the South Australian Government with a key initial task of leading the development of the South Australian Mental Health Strategic Plan (the Plan). A draft of the Plan is due for completion in August 2017 and the final Plan in October 2017. We are in the process of finding out what is currently happening around mental health and wellbeing in SA, and what the needs are.

What this paper is about?

This paper is a summary of what we heard from over 2,270 South Australians who shared their ideas on mental health and wellbeing in order for us (the South Australian Mental Health Commission) to develop SA's Mental Health Strategic plan. We have analysed the information given to us and identified key themes.

How did we hear from people?

We sought feedback from South Australians in a range of ways including:

- > Direct submissions invited via our website, Facebook page, yourSAy, on-line chat, direct email or post
- > Community conversations with a broad range of stakeholder groups and community representatives
- > Facilitated or 'Do-It-Yourself' (DIY) options included small or large group conversations, community forums, creation of art, poems, comics, zines, stories, photos or videos, pop-up stalls or any other techniques which people felt would capture their feedback.
- > An on-line survey

What did we ask?


We asked people to let us know:

- > What is working with respect to promotion of mental health and/or prevention or support for mental ill-health
- > What is not working so well
- > What key research is being undertaken, and what might the future look like?

Whom did we heard from?

The Commission listened to over 2,270 South Australians including a diverse range of individuals, organisations and groups. This number included 147 people providing or contributing to submissions primarily via written documents but also via submissions of visual art or poetry, 1,175 people participating in 176 community conversations held in a broad range of locations across the State and 952 people responding to the online survey.

We are grateful to everyone who has shared their thoughts, experiences and suggestions with us. We have been very excited by the scope and depth of your feedback. If on reading this paper you feel



your ideas have been missed please be assured it has been seen and will inform not only the strategic directions of the plan, but also help guide us in carrying out other projects around promoting and strengthening the mental health and wellbeing of South Australians.

What happens next and what are we seeking from you?

This paper is out for consultation until 12 July and we are encouraging people to write to us, phone us or complete a short on-line survey to provide feedback.

We are seeking your feedback on the following questions:

- 1) Are there any broad themes that you feel we have missed?
- 2) Are there any areas where you feel we have not captured what was said?
- 3) What are the themes that resonate with you?

All your feedback will be collated and used alongside this Discussion Paper to inform development of the Plan.

How can you provide feedback?

You can provide feedback via this survey link: <https://www.surveymonkey.com/r/SAMHCkeyfindings>

Commission staff will also be at locations across metropolitan Adelaide and some of the country locations we didn't get to in the first round of conversations. These include Ceduna, Kangaroo Island, Murray Bridge, Mt Barker and Gawler / Barossa.

Details of when and where Commission staff will be are on our website www.samentalhealthcommission.com.au.

Summary of key themes

KEY THEME: Importance of promotion, prevention and early in life intervention

- > Let's act early in life
- > We want similar programs across all schools, and we want qualified school counsellors
- > We need to build on the work already happening to generate and grow mentally healthy workplaces in SA
- > Older people need support not only to remain physically well, but also to remain mentally well
- > Loneliness and isolation are widespread – people are crying out for a sense of community connectedness and wellbeing

KEY THEME: Community education to improve awareness and reduce stigma

- > Improve community awareness and understanding around mental health
- > It's time to rethink the language and definitions used around mental wellbeing, mental health and mental ill-health

KEY THEME: We need services that work together

- > Services to work better, together
- > Safe secure housing and money to meet my needs

KEY THEME: We want the right care in the right place at the right time

- > Where do I go to get help?
- > We need affordable, accessible primary mental health care services
- > We need services that support people in distress before they reach crisis
- > We need more community based services

KEY THEME: Providing services that better meet people's needs

- > People want to guide their care
- > People want options
- > We need to expand our lived experience workforce
- > Look at alternative workforces
- > Families and friends want to be included and supported
- > We need training in the areas of mental health, trauma, crisis, recovery and/or person-centred care to allow skilful and compassionate responses to people experiencing mental distress
- > It's all about relationships – I don't want to tell my story over and over again



KEY THEME: The right support for our diverse communities

- > Transitions: Things can get tricky around times of change
- > People want care that is relevant to their age and situation
- > Looking at diversity
- > Tailored responses

KEY THEME: We need to plan for it – planning, funding and review

- > Funding models which recognise continuity, innovation and sharing
- > Setting examples from the top down
- > Helpful data

Key themes we heard from South Australians

KEY THEME: Importance of promotion, prevention and early in life intervention

Let's act early in life

What's working?

We heard that a healthy start to life strongly impacts positively on mental health and wellbeing. We heard from people and departments involved in early childhood work, that there are some great initiatives now available or being implemented for vulnerable families. For example, 43 Children's Centres in SA offer services focusing on children's learning and development within the context of their family and community.

What's not working?

We heard that there are times where mothers and babies may be identified as high risk due to trauma, domestic violence, drug and alcohol issues, but that a lack of resources means that people only receive a service once they are in crisis.

What do we need?

Resources and 'soft entry points' into services to develop parenting capacity and attachment in the first two years of a child's life and throughout their development, although we also heard that there is a lack of clear definition of what 'parenting capacity' actually means.

Relationships take time, people and services need to be embedded into the community so parents feel safe to access support, whatever that may be. We heard that there is a need for programs which support the secure attachment of infants to parent figures so that resilience and skills are built from infancy that translate into a greater ability to relate in later life.

Investment in the period from before birth and through toddlerhood is critical not only for child development but also for building protective factors to help prevent mental health issues later in life.


We want similar programs across all schools, and we want qualified school counsellors.

What's working?

We heard about a lot of different programs in our public and private, primary and secondary schools to build mental wellbeing and resilience in our children and young people (e.g. Kismatter, mindfulness training). We heard that by investing in these programs, "we are growing a generation with a much more heightened awareness of their abilities to manage their health and wellbeing."

What do we need?

There was a clear call for a state-wide, consistent and systematic program for building and supporting wellbeing and resilience in our school-aged children, as well as in our universities. This would involve an agreed and coordinated approach to wellbeing and resilience measurement, training and implementation, programs targeted to transition points in schooling life, and with ongoing support. It would need to



ensure that is also reached children and young people who are not attending school or who are enrolled in flexible learning options.

We also heard that teachers and support staff may need training and education on how to recognise and support children for whom general wellbeing and resilience training may not be appropriate at that time. These may include children who have already experienced, or who are experiencing, significant trauma. These children may need help to effectively manage relationships, including relationships with services, before or alongside wellbeing and resilience training.

We heard from many young people, as well as youth support services and other non-government organisations (NGOs), of the need for trained, qualified counsellors to be available in all schools. Students and staff also asked for an efficient referral system from universities to the acute mental health sector.

Additional support may be required for children and young people who are:

- > lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ)
- > from Aboriginal or CALD backgrounds
- > experiencing learning difficulties
- > living in disadvantaged households
- > in out-of-home care
- > who enter the criminal justice system
- > children of parents experiencing mental ill-health.

We need to build on the work already happening to generate and grow mentally healthy workplaces in SA

What's working?

We heard several positive examples of where organisations, both large and small, had implemented worker wellbeing initiatives suited to the needs of their staff. Several SA Government departments and private companies reported on wellbeing initiatives in their workplaces in annual reports.

We heard about numerous organisations (e.g. Return to Work SA, Heads Up, Black Dog) promoting the importance of workplace mental health and wellbeing, and recognising that workplaces can contribute both to protection against, and/or development of, mental health issues.

What's not working?

Many South Australians described their personal experiences of workplace stress, bullying or lack of support as contributing negatively to their mental health. We also heard many stories of workplaces not being supportive of people with existing or emerging mental health issues.

People felt that in general their workplaces didn't know how to discuss mental health issues with staff, how to create mentally healthy workplaces or understand what they may look like, and how to talk to and support people with mental health issues.

What do we need?

Education and support for workplaces and staff on how to prioritise and maintain worker mental health and wellbeing.

Older people need support not only to remain physically well, but also to remain mentally well

What's currently happening?

We heard from older people that a greater emphasis on delivery of services to people in their homes has led to a sense of isolation and withdrawal for many people, particularly when their physical health declines.

What do we need?

There was a call for greater emphasis on supporting community connection through peer support groups and community activities, including for people receiving support from Older Person's Mental Health Services.

We heard from older South Australiansthat priorities for their wellbeing are:


- > Home, community and environment – creating inviting and accessible spaces, encouraging a sense of community, and enjoying nature and taking care of the environment
- > Making a contribution – opportunities to contribute, learn and participate
- > Making it easier to get around – well-maintained paths and reliable transport
- > Intergenerational connectedness – bringing together people of all ages and stages of life in our communities
- > Age friendly services – services mindful and respectful of the needs of older people.

Loneliness and isolation are widespread – people are crying out for a sense of community connectedness and wellbeing

What's working?

We heard some great examples of where communities or councils had developed their own 'grass roots' wellbeing initiatives, particularly in country SA. For example, Mentally Fit Eyre Peninsula is a program created by local people for local people to empower the community with understanding and tools for mental health and wellbeing. Several local councils told us about their role in creating connectedness between people in the community.

We heard that opportunities for community connectedness helped people to find support as well as helping others – *"not just about the me, me, me."* We were given many examples of how this was occurring in both city and country locations, including at local sporting clubs, churches, volunteering, art groups, choirs, blacksmith groups, and poetry groups. People said they felt that *"the way we plan our suburbs is critical to improving mental health outcomes"*, and such plans may include community hubs, suitable public transport and green spaces to build stronger connections in the community.



We heard the SAHMRI Wellbeing and Resilience Centre is progressing the work around positive psychology at a community level through programs and training. We also heard that there are other tools for promotion of wellbeing being used overseas and in other parts of Australia.

What's not working?

Older people told us that whilst being supported in their own homes could be a good thing, often loneliness was a big issue when physical health problems impacted their ability to interact with friends.

Young people told us that leaving school was a particularly difficult time, as they lost connection with their school community. People told us life without friends was very depressing.

We heard from people who had experience of psychosis that they *“put up with processes like diagnosis or forced medication when the need for human connection became so urgent that the trade-off and risks seemed worthwhile”*.

We heard from people in the community who had lived in the same house for three years but never met their neighbours. We heard from people lamenting the loss of local community, the ‘village square’, and the ability for ‘villages to raise our kids’. Some councils told us that even if they had funds available they would be unsure how to progress mental health or wellbeing initiatives in their communities, or what their responsibilities were in this regard.

In some country areas people told us that there was a sense of hopelessness which had pervaded the community. And we heard from Aboriginal communities about how essential it is to have safe places or spaces where the community can gather and yarn to support and teach one another.

What do we need?

Spaces for people to connect and make friendships with people of their choice was seen as critical. A sense of meaning, purpose and a reason to get up and go out were also highlighted as important to provide a sense of wellbeing.

Many people felt that there was a need to build a sense of wellbeing not just at an individual level, but also at a community and population level. It was acknowledged that this was hard to define, and is likely to be more than addressing the known social factors impacting mental health and wellbeing such as housing, health, good relationships and employment.

KEY THEME: Community education to improve awareness and reduce stigma

Improve community awareness and understanding around mental health

What's working?

People acknowledged that campaigns to reduce stigma associated with depression and anxiety had raised community awareness, understanding and willingness to seek help. Young people told us that television shows with the message *“mental ill-health is part of life and nothing to be ashamed of”* were helpful as they normalised mental ill-health and reduced associated stigma.

What's not working?

People told us there is still considerable stigma and lack of community understanding associated with other mental illnesses such as schizophrenia, borderline personality disorder, and psychoses.

We heard from individuals, community groups, support groups, Aboriginal and culturally and linguistically diverse (CALD) communities, and NGOs in both city and country locations, that fear of stigma and shame stopped people being open about their struggles with mental ill-health. In many instances, it stopped them seeking help altogether.

This was either based on previous negative experiences at school, work or in other aspects of their lives, or around fear of what may happen if they disclosed. We heard that in rural and remote areas many people were reluctant to seek help as they felt ashamed in a community where people all knew each other.

People not only told us they felt shame about struggling with mental health issues, but we also heard from many people who felt huge shame and difficulty in being open about traumatic experiences or other factors that may have contributed to mental ill-health. Traumatic experiences were reported to include childhood abuse or neglect, domestic violence, or major life crises. It was also clear that the definition of 'trauma' in this context was ill-defined and inconsistently understood. In some cases, we heard that disclosure regarding trauma experiences had led to a withdrawal of support due to concerns about eligibility criteria, professional competence or lack of knowledge on how to best support people.

We heard from individuals and groups of people, in particular people with trans or other gender diverse identities, that experiences of stigma and discrimination in relation to their gender identity had also impacted negatively on their mental health and had led to difficulty being open or accessing services.

People told us that *"if things were working well, we would not need an 'RUOK' day"* as mental health would be part of everyday conversations. People would no longer feel that seeking help may be perceived as a sign of weakness, but rather be seen as taking an active role in maintaining their mental health.

What do we need?

Many people are calling for broad community education around mental health and mental ill-health, and also around trauma and diversity.

We heard that campaigns to reduce stigma associated with mental illnesses including, but not limited to, schizophrenia, borderline personality disorder, and people in general who experience psychoses needed to be widespread and sustained.

Widespread training in 'mental health first aid', which provides trauma informed first responder support similar to physical health first aid, is needed for people working in health services, first line responders, teachers and support staff, school students, university staff and students, pharmacy staff, prison officers, welfare service staff, GP receptionists and the community more broadly.

People suggested that community education should be tailored to the age or background of the target group, and could offer 'toolkits' of practical steps for supporting people around mental health problems or suicide prevention.

It's time to rethink the language and definitions used around mental wellbeing, mental health and mental ill-health

What's working?

Many people said they felt that diagnoses were helpful to access services and enabled them to understand their experiences.

What's not working?

Other people reported that getting a diagnosis or a 'label' meant that they were reluctant to seek help as they were worried about potential negative implications for employment, insurance and access to support.

We also heard from a range of people and service providers that diagnoses can become labels which 'over-medicalise' normal human experiences such as grief, and/or can take the focus away from factors that are contributing to mental ill-health. People said they felt that for the most part, when we talk about mental health, we have historically talked about it in medical terms of illness or absence of illness, rather than understanding that mental ill-health and mental wellbeing can co-exist.

Several people commented that use of the word 'mental', in reference to both people and services, contributes to stigma. Suggested alternatives included the term 'emotionally ill' or 'needing help with emotions', or relabelling mental health services as 'wellbeing centres'. From some people experiencing psychoses, and voice hearing in particular, we heard that the voices could be valuable and "*should not automatically be considered abnormal psychology, but rather a natural variant like nightmares or sleepwalking.*"

What do we need?

A concerted community awareness and anti-stigma campaign alongside new thinking about mental health definitions.

KEY THEME: We need services that work together


Services to work better, together

What's working?

People shared examples of connection across services and systems to consider whole of person needs. These included but were not limited to several rural and remote locations where staff in different sectors were more likely to know each other, and partnership structures such as Multi-Agency Protection Services, and Partners in Recovery focused on coordinating service provision to people experiencing complex mental illness and other issues.

What's not working?

We heard numerous stories about people who had been turned away from mental health services because they had a substance abuse problem, or turned away from drug and alcohol services because they had a mental health issue. Service providers told us that part of the reason for this is that many staff



feel inadequately trained to manage people presenting with alcohol and other drug related psychoses for example.

People shared concerns that there are insufficient mental health services for people with physical health problems, but also that there is insufficient focus on the physical health of people with mental health problems. We were provided with references and research and personal stories, indicating that effective mental health care in conjunction with quality physical health care can improve quality of life and outcomes for people and also reduce pressure on the health system.

We heard that whilst there are many examples of where state government mental health services, other government service providers, private health networks (PHNs), general practitioners (GPs), NGOs and the private sector work well together to ensure people's needs are met, often these examples rely on personal relationships rather than systemic structures or processes.

In some cases, we heard there was a “*shaky and tenuous collaboration*” between NGOs and government service providers particularly between and across mental health and other services areas (eg disability, homelessness). People also told us that funding is not always currently available to support the time and resources involved in establishing and supporting integrated service delivery. There was a call for greater connection and communication and less silos between government sectors themselves.

Many South Australians we listened to were concerned by a lack of continuity of care and active follow up when moving across and between services, in particular after being discharged from a mental health service to an NGO or GP. We heard numerous stories where lack of follow-up resulted in a worsening of their mental health and meant they needed readmission.

What do we need?

Greater integration across multiple service sectors and providers to ensure that people receive the care and services they need and do not fall through cracks between and within services and systems. Greater integration of services that work in the same area (e.g. services involved in supporting both mothers, infants and families in the area of perinatal depression). This may include structures to support collaboration, partnership and a ‘joined up’ approach across agencies, sectors, services and systems.

A safe and easy way to share data and service experience between and across government and non-government services.

Some service providers and PHN staff said they felt that services need better ways to follow-up with GPs and provide more tools and resources to help people move back into their community when discharged.

Safe secure housing and money to meet my needs

What's working

People told us that safe and secure housing and access to employment make a difference to mental health and wellbeing.

Supported accommodation programs such as the Housing and Accommodation Support Partnership (HASP) program where people are supported to live in the community are working well. Programs like Individual Psychosocial Rehabilitation Support Services (IPRSS), PIR and Personal Helpers and Mentors (PHaMs) work well and support people to access the supports they need such as safe and secure housing.

What's not working

We heard from many people about the negative impact on mental health and ability to manage as a result of:

- > no home
- > no job
- > difficulty getting financial support
- > loneliness and isolation.

We were told that when people go into boarding and rooming houses, some services no longer consider them to be homeless and welfare supports cease as a result. The often episodic nature of mental ill-health means that people hospitalised for acute care risk losing their home or job because they have been unable to pay their rent or attend work. This creates more stress and impacts on people's mental health.

Accessing support via Centrelink was reported by several people to be "*traumatising and shaming*". We also heard that people with mental health issues can experience discrimination and difficulty accessing health insurance coverage and making claims.

Financial stress can significantly impact people's mental health, and we heard from people with mental ill-health, young people who were homeless, and people in rural and remote areas that finding their way through the welfare system and dealing with staff who were less than helpful can all lead to additional mental distress.

What we need

A variety of safe and secure housing options to be available to people, including in rural and remote communities. A greater number of mental health supported accommodation packages such as those available through the HASP Program.

Pathways to employment and incentives for people recovering from mental ill-health to work.

Adequate social and financial welfare.

KEY THEME: We want the right care in the right place at the right time


Where do I go to get help?

What's working?

People told us about creative approaches to providing care in country areas. For example 'one stop shops' have been established to provide integrated care for people in several locations and we heard about men's support groups growing organically within rural communities to provide support. In some locations, one stop shops specific to the needs of youth and young adults were an important part of the community.

We heard about communities of interest (such as choirs, artist groups) coming together to offer support.

What's not working?



We heard time and again that people did not know where to go for assistance with mental health concerns (ranging from mild distress to crisis to ongoing community support) or that if they contacted a service the service system was difficult to navigate.

Rural and remote communities told us that a lack of ready access to timely and appropriate services and support for mental health issues is a key issue. Waiting lists to access services are not helpful and having to travel to access services puts additional pressure on people living in the country.

People told us mainstream mental health services may not be culturally appropriate or sensitive to the needs of Aboriginal people, people from CALD communities, or LGBTI people.

For people with complex mental health needs, access to services can also be difficult. For people with specific mental health issues such as eating disorders, statewide services based at one location were described as difficult to access for many people.

What do we need?

Clear, current and easily available information so that people can access the support or service they need regardless of how it is funded.

Targeted information approaches are needed for various age and population groups to know how to access appropriate mental health care and support.

People told us that “*mental health problems don’t happen between 9am and 5pm, Monday to Friday*”, and that 24/7 access to appropriate support is required.

A greater role for “*any workforce outside health with skills in relationship building and communication who may be able to provide peer based supports*” to assist people in their communities and help prevent the need for hospital admissions. In country locations this may include an expanded role and infrastructure for community pharmacists, GP receptionists, other allied health professionals, Aboriginal Health Workers, counsellors or the peer workforce.

We need affordable, accessible primary mental health care services

What’s working?


South Australians told us about people in primary health who go out of their way to support people or their community in times of need.

What’s not working?

Ten Medicare-funded psychologist sessions per year is in many cases inadequate to address the need and establish a therapeutic relationship. Paying the gap cost of the first ten sessions (where charged), or paying for additional sessions after the first ten, stops people from accessing the help they need.

Long wait lists don’t work for people who need help with mental health issues. We heard that these wait lists exist in both the city as well as rural and remote locations. Wait lists are long for private psychologists or psychiatrists, with access to child or adolescent psychiatrists being extremely difficult.

Several people told us that these long wait times often resulted in emergency department presentations either because the situation reached crisis or because they could see no other way of accessing help.



Access was also limited in some cases because people could not afford the public transport costs to access services, or could not afford the service itself if they were ineligible for Medicare (e.g. international students).

What do we need?

More opportunities to access affordable supports

We need services that support people in distress before they reach crisis

What's working?

People, families and service providers all told us that crisis respite programs (previously funded but no longer available) had provided an easy to access and valuable service in a non-clinical service environment, and this avoided the need for hospital admission for many people.

What's not working?

We heard from many South Australians who felt that the current mental health service system was “*crisis-driven*” due to a lack of investment in options for prevention and early intervention (which people acknowledged may be “*more difficult to measure*”).

Early in life intervention is not happening in the way it should be. We heard that there is a need to put greater investment in the first two years of life to ensure that parents have the skills and resources to support infants and children to grow up with secure attachments, by providing safe and protected environments.

We were told that it isn't helpful when timely or consistent follow up after a mental health crisis do not occur.

What do we need?

We heard a strong message from the South Australian community that there should be greater focus on mental health services aimed at hospital avoidance. However, this should not be at the expense of acute hospital based services for those who need this level of support.

Appropriate community support, tools and techniques to assist people to stay well after discharge from mental health services, and timely follow up, can assist people to avoid hospital re-admission.


We need more community based services

We heard from many people about the valuable role played by NGOs and community organisations in supporting people experiencing or recovering from mental ill-health in the community. Many people told us about the importance of employing and training a lived experience workforce to provide peer-based support to provide hope for people experiencing mental health issues.

KEY THEME: Providing services that better meet people's needs

People want to guide their care

What do we need?



People told us that they want service providers to recognise that people's backgrounds, experiences, cultures and preferences will impact the type of care and support they may want and need.

We heard examples where physical health problems or social circumstances were significant contributors to mental health issues and people felt that they should be the primary focus of help at that time. Others told us that past traumatic experiences and current mental health issues were significant contributors to physical or social problems. Most importantly, people wanted their lived experience to be listened to when planning treatment, and their wishes respected. If their wishes are unable to be met, to be provided with good and sound reasons why not.

People want options

What's working

People told us of positive experiences where they felt valued as an integral part or driver of their mental health care.

What's not working?

Not having choices and/or not being able to talk openly with support people about what options are available.

Feeling fearful that making a choice might result in that choice being taken away.

Whilst many people found medications invaluable to their recovery, others found that medication actually led to more distress or was not helpful, particularly when forced.

What do we need?

A range of funded or affordable options needs to be provided to support building and maintaining mental health and wellbeing. People's experiences and needs are all different, and a 'one size fits all' approach is too often applied but rarely appropriate.

People are also seeking a reduction in coercive or forced treatment.

We need to expand our lived experience workforce

What's working?


We heard a great deal about the value of peer support, peer workforces and/or peer led services.

What's not working?

People told us that there was scope for a peer workforce to be more consistently involved in:

- > delivery of targeted or widespread mental health first aid training
- > peer-led crisis respite centres
- > provision of peer based support services (particularly in country areas)
- > potential roles within emergency departments, sub-acute services and with SA Police or other first responder organisations.

What do we need?



A systematic and planned approach to the lived experience workforce to ensure consistency in access, support and accredited qualification across services.

Looking at alternative workforces

What did we hear?

We heard from trained counsellors that they may also have a valuable role to play in provision of non-crisis support or intervention for people at risk of or with mild to moderate mental ill-health. However, we also heard from counsellors that there was substantial variability in qualifications and training of persons who called themselves counsellors, and some felt that a minimum qualification or accredited standard of training may need to be specified.

We also heard that there may be opportunities to expand the role of pharmacists or mental health nurses particularly in rural and remote areas.

Families and friends want to be included and supported

What's working?

We heard that carer consultants can play a key role in supporting families and friends to understand ways to support the person with mental health issues, how to manage their own mental health and wellbeing, and how to access other supports available to them.

What's not working?

Families and carers of people experiencing mental ill-health told us that they often felt unsupported and in many cases, excluded from decisions regarding the person's care, despite the person's permission to be included or playing a key role in care.

We heard from agencies working with people with severe and complex mental ill-health or other circumstances, that families and carers often play a key role and should be actively included and consulted in care processes wherever possible.

Carers also need support to “*keep their own heads above water*”. We heard that carers often get little break or support, making employment and social engagement difficult. Children of parents or siblings with mental ill-health also play a caring role, and if unsupported may be at risk of developing mental health issues themselves.

What do we need?

Involvement of and information sharing with families and other carers in decision making wherever possible.

We need training in the areas of mental health, trauma, crisis, recovery and/or person-centred care to allow skilful and compassionate responses to people experiencing mental distress

What do we need?

People told us that a broad community awareness campaign as well as targeted training for specific workforces would improve community understanding and reduce stigma associated with mental ill-health. It would also improve the ability of workforces to respond skilfully and compassionately to people experiencing mental distress.

We heard that within specialised mental health services, a coordinated, consistent and systematic approach to staff training would be beneficial to ensure ongoing professional development in new evidence based practice or models of care.

Additional training for mental health staff could include:

- > trauma informed practice
- > a developmental approach across the lifespan
- > approaches for management of or intervention for substance misuse, and
- > education to increase awareness and sensitivity to the needs of particular population groups such as Aboriginal people, people from CALD backgrounds, and people who are gender or sexually diverse (see Section **Error! Reference source not found.** for further discussion).

We also heard that training for mental health service staff should include non-clinical staff and also volunteers. We heard that other clinicians not directly employed in specialised mental health services but with responsibility for assisting people with mental health issues may also benefit from additional and ongoing training opportunities in mental health and related areas. These clinicians particularly include GPs and staff working in emergency departments.

Alongside a need for specialised training, we also heard that *“mental health workers need great support to deal with the hard and wonderful work that they do”*.


It’s all about relationships: wherever possible, I want the same person to provide my care – I don’t want to tell my story over and over again

What’s working?

Some NGOs and other organisations (e.g. Headspace) reported that they *“follow people into and out of services, which provides stability, continuity and ongoing connection in and out of hospital by liaising with ward staff and family.”*

What’s not working?

We heard that the ability to establish a therapeutic relationship was being compromised for many people due to the cap on Medicare funded psychology services, and also by a lack of staff continuity between community and hospital services.



We also heard that for people with ongoing mental health issues, the current system split and change of worker, practitioner or provider at times of key life transition points could be distressing. This includes the age-based split between childrens, adults and older persons services.

What do we need?

Opportunities to form and structures that support the building of consistent therapeutic relationships to assist people in their recovery from mental ill-health and/or for ongoing support for mental health.

KEY THEME: The right support for our diverse communities

Transitions: Things can get tricky around times of change

We heard from many stakeholders including people with lived experience, NGOs, psychiatrists and other mental health clinicians that *“transition times are where people get missed”*, and that these are the times where people are often most vulnerable to mental health issues.

We were told that this was particularly important for young people moving from primary to secondary school and for school leavers, as half all common mental ill-healths arise by the age of 14, and three-quarters by the age of 24. But it was also important for children starting school, for new parents, those leaving the workforce either voluntarily or involuntarily, and for people entering aged or other care.

What’s not working?

Many government funded services and departments are currently age-based, and age cut-offs can vary by department and organisation. We heard that this can make service integration and coordination difficult across sectors.

For children brought up in out-of-home care including those under the Guardianship of the Minister, we heard that transition to ‘adulthood’ can be extremely distressing and traumatic. Many of these children have already experienced significant trauma or hardship in their lives, then at age 18 are no longer eligible for ongoing out-of-home care. Not only are they expected to be able to live independently from their 18th birthday, but we heard that *“the mental health care system they previously relied on won’t accept them anymore and they are forced to navigate an adult system not set up for their types of issues.”*

What do we need?


Service planning and provision that is mindful of and responds to need for extra support and continuity of care during transitions. Help may include accessing services, employment or further study.

Flexible service responses to be able to support continuity of care.

People want care that is relevant to their age and situation

We were told that different broad age groups may require different approaches to prevention of and intervention for mental health issues.

What’s working?



Young people told us that things working well to support mental health and wellbeing include beyondblue chatrooms and other online support, headspace, and community organisations or groups (e.g. churches) with youth friendly facilities. We heard many reports that the colours and physical space at headspace services was inviting for young people.

Youth mental health services provided by one of the Local Health Networks (LHNs) reflected that by providing an Assertive Community Treatment model they were able to engage young people in the spaces and places they felt most comfortable and safe to be in. Giving clinicians and young people the freedom to engage where they felt comfortable and safe was essential.

Young people reflected the use of the internet as a useful 'soft entry'. The internet is used regularly to access information about mental health and mental ill-health.

What's not working?

We also heard strong feedback from many in the community that the current youth model of care for provision of state-run youth mental health services in SA is not working. We were told that there is *"currently no uniform delivery [or resourcing] of Youth Mental Health Services across the different LHNs"*, and that 16-18 year olds did not always know what service they belonged to or how to access support.

We heard that Child and Adolescent Mental Health Services (CAMHS) is often involved with at-risk children, many of whom have experienced trauma or adversity in early years. However, we heard that resources often get prioritised to emergency and acute interventions rather than early in life intervention.

Many clinicians and service providers were disappointed at the discontinuation of the National Perinatal Depression Initiative in 2013.

What do we need?

We heard from several clinician groups and service providers that a focus on early in life intervention, particularly for at-risk children and families, had demonstrated success not only in individual outcomes but also community based understanding and support for wellbeing and mental health. Additional resourcing, skills development and service integration may assist in offering greater support to mothers and children who have experienced or are experiencing trauma, domestic violence, drug and alcohol issues, mental ill-health.

We heard that the needs of adolescents and young adults are very different from those of children and adults, and that they require specialised support. People told us that a consistent and well-resourced service was very important in this age group, given the high prevalence of mental ill-health and first presentations of mental ill-health at this time of life.

The utilisation of e-mental health initiatives can enable young people who may not have access to face-to-face services to acquire information and treatment and can assist practitioners to expand the options for interventions that they can provide.

Older persons experiencing mental ill-health may also require specialised services. It was not clear during our conversations whether Older Person's Mental Health Services offer a consistent model of care across different LHNs, or whether a greater and broader focus on older persons' mental health and wellbeing is required.

Looking at diversity

What's working?

People told us that Aboriginal Community Controlled Organisations such as Nunkuwarrin Yunti and Pika Wiya, provided services that the community could trust, and know that they would be treated with respect when accessing social and emotional wellbeing services. Approaches that people found helpful in supporting social and emotional wellbeing were Aboriginal staff, yarning groups, men's sheds, traditional healers, "*documents written by Aboriginal people for Aboriginal people*", and recognition of the need for ongoing funding and access to care in rural and remote locations.

Services providing gender neutral services work well for people who identify as gender and sexually diverse.

We heard that OARS Community Transitions works with social workers, prison officers and Prison Health to help with prisoner release back into communities, but do not have the resources to work with every prisoner on their release.

What's not working?

We heard that mental ill-health was still a sensitive topic associated with shame, and that mainstream services were often unintentionally racist in their approach and did not always understand intergenerational trauma, grief and loss experienced by Aboriginal people.

Transgender and other gender and sexually diverse people told us that mental health services are often intentionally or unintentionally discriminatory against these groups. We heard that lack of access to appropriate gender-neutral or other restroom facilities, inappropriate questions or restricted options on forms, and non-inclusive language indicating lack of understanding from staff, can all contribute to a worsening of mental distress.

All CALD communities that we heard from indicated that knowledge and understanding of mental health issues was limited in their communities, and that there was significant stigma and taboo associated with mental ill-health. Many cultures do not have words for 'mental health' or 'mental ill-health'. People also spoke about the imperative to keep mental health issues hidden in a culture where the whole family would be seen as 'tainted'. The impact of stigma was strongly associated with a sense of shame and this has a compounding effect on a person struggling with mental ill-health. This also meant that people from CALD communities may not always want to talk to someone from their own culture about mental health issues.

We heard that people in prison had limited or inadequate access to mental health services and supports. Despite a high rate of mental health issues, we were told that access to a psychiatrist in prison was "*virtually zero*" unless the person was under a forensic psychiatrist – "*ten minutes with a psychiatrist every six months does not help*". People told us that greater access to social workers and potentially peer workers may be beneficial, but that resources are limited and provision of in-reach services was difficult due to lack of resources for supervision.

We heard that provision of mental health care for forensic clients is intensive at the point of admission but not at the point of discharge. This was reported to be counter to evidence suggesting that the greatest point of relapse is closer to discharge, and that suicide risk is highest in the first seven days post discharge.

What do we need?

We heard strong messages from many different groups in the community that services and service planners needed to be mindful of the specific needs, backgrounds and experiences of particular population groups with respect to mental health and wellbeing. We also heard the importance of people having contact with services where staff were from a similar background and may have a more intuitive understanding of particular cultural or other impacts on mental health.

People we spoke to from Aboriginal communities or services told us of the importance of encouraging and facilitating community based supports in this area – *“local people need to talk to local people, need to hear real stories from family members.”* We heard that adolescent social and emotional wellbeing was an area of need in Aboriginal communities, and that elders play a key role in providing guidance and support to young people (but that there were now fewer elders to provide this role).

Greater workforce training around gender and sexual diversity for people working in mental health.

People from CALD communities are seeking more community education and conversations where people feel safe to talk about mental health issues, more peer support networks, culturally appropriate resources and services, and systemic change to combat stigma and racism.

Additional training for prison officers in mental health and trauma informed practice to build their skills in working with people with mental ill-health.

Tailored responses

What do we need?

Around 3% of our population experience severe mental ill-health. Some people have episodic illness while others have more persistent forms of mental ill-health that can reduce their ability to function, experience full physical health or manage the day to day aspects of life. People need unique clinical and community support and a coordinated approach to meeting other ‘non-health’ needs which often requires a range of services and providers. We heard that some people with complex circumstances do not readily engage with services and systems, whilst others remain for extended periods in acute inpatient services, and place a heavy demand on such services due to a lack of appropriate options for community housing and support or alternative models of care and support.

Whilst we did not seek specific feedback on the availability or adequacy of services for people experiencing different kinds of mental ill-health, many people told us that a specific action plan for people with Borderline Personality Disorder (BPD) would be welcomed as *“services are currently suboptimal for this group of people and their families and carers”*.

We also heard that where statewide services are provided (e.g. for eating disorders), that services must ensure that these are in fact accessible, appropriate and relevant for people state wide.

We heard from councils that provision of helpful ways to have conversations with people about hoarding and squalor would be valuable.

KEY THEME: We need to plan for it – planning, funding and review

Funding models which recognise continuity, innovation and sharing

What's working?

We heard time and again of the importance of NGOs in the provision of non-clinical community support services. People told us that the shift to more individualised fee-for-service funding arrangements under the National Disability Insurance Scheme (NDIS) had forced many NGOs to think creatively and innovatively in the way they are providing services.

What's not working?

We also heard that short term funding models for NGOs and also for specific regional or Aboriginal programs, can lead to difficulty attracting and retaining staff and can result in:

- > lack of continuity of service provider
- > inability to forward plan
- > inability to build therapeutic relationships which may be critical to longer term program outcomes, and
- > difficulty collecting data to inform longer term outcomes.

We also heard that competitive funding arrangements now mean that NGOs are often in a position where they are competing for funding, and that this can impact the ability of NGOs to work together or share innovative practice.

Within government-run services, we heard that there had been a shift in focus from service delivery to ensuring ongoing funding, and that this had impacted opportunities for collaborative or shared approaches to care delivery, and reduced capacity for innovation.

We heard from NGOs and individuals that current ambiguity around NDIS funding for psychosocial services risks loss of professionals and valuable staff currently providing these services. There is also a fear that community services and supports for people who experience mental ill-health but are not eligible for NDIS “*will disappear without some block funded services, and result in an increased need for acute services*”. This included uncertainty regarding the future of supported residential facilities for people with high and complex circumstances.

We also heard that current Medicare rebates for GPs may lead to a financial disincentive for GPs to work with people’s mental health issues – “*mental health frequently gets lost in GP land as it opens up a pandora’s box that cannot be fixed in ten minutes*”. We heard that whilst GPs are promoted as the first contact point and are well placed to act in a primary care role, they often do not have the time or understanding to recognise or explore the background trauma or other issues that may be contributing to mental ill-health presentations.

What do we need?

Stable and ongoing core service investment to ensure that people who need help do not fall between service provider gaps.

Doing what's right for the person

What's working

We heard from staff in several NGOs and also state-run mental health teams about their positive work culture, longevity of staff in positions, and collaborative approach to “*stopping at no point*” when providing services which engage and support people in their care.

We also heard from people with lived experience and clinicians that where clinicians were able to take the time to provide genuine, kind and dignified care that this was extremely helpful to achieving therapeutic outcomes.

What's not working

Staff of mental health services told us that they lack resources and time to engage in proactive rather than reactive care, and are getting burnt out due to high caseloads and insufficient time to provide the care that they would like to. We also heard from staff that mental health services can be risk averse or restricted by budget, and that some staff do not feel supported to develop or try innovative approaches to providing or improving therapeutic care.

We heard that there are increasing numbers of people being accepted into mental health services with a range of drug and alcohol issues, and that mental health service staff feel inadequately trained in this area, and rarely have access to drug and alcohol staff in their workplaces.

What do we need?

The person's lived experience needs to be valued and included in the therapeutic relationship.

Support for staff to enable them to work in the best way possible.

Services which are able to respond flexibly to the requirements of the population.

Setting examples from the top down

What's working

People welcomed a whole-of-government approach to mental health, and agreed that mental health and wellbeing were “everybody's business.”


What's not working?

However, we heard concerns that an ‘everybody's business approach’ requires very clear articulation of responsibilities and means of accountability. Without this there is a risk that no organisation or service will be held accountable for delivery or implementation of reforms and initiatives.

What do we need?

Leadership in mental health services to be forward thinking, creative and accountable.

Joint planning to clarify responsibilities and ensure a minimisation of service gaps or duplications.



A mental health and wellbeing planning approach that has capacity and clear accountability for ensuring state and national plans and policies are implemented whilst still allowing for potential differences in regional needs and allow for big picture, statewide thinking.

We also heard about the strong need for consideration of mental health needs in infrastructure planning. In particular, separate spaces for females and males in acute mental health units, as females are currently being placed at high risk in some of these environments.

Helpful data

What's working?

We heard from LHNs that implementation and reporting on models to decrease length of stay and emergency department wait times *“appears to be working”*.

We heard about the wellbeing and engagement collection (WEC) survey within the Department of Education and Child Development (DECD) that collects information from students in Years 4 to 9 about non-academic factors relevant to learning and participation. The survey gives schools, the community, and government an insight into what needs to occur to ensure students experience success and are provided with resources and opportunities to reach their full potential.

What's not working?

We heard that the current statewide Key Performance Indicators around mental health are not applicable to forensic services, that there is no measure of a person's experience across multiple sectors and services, and that there is no measure for the outcomes of preventative services or activities.

What do we need?

Meaningful performance measures that are based on outcomes and service experience rather than activity focussed.

Data to inform decision making around service development, performance and resource utilisation, and to progress development of information systems in line with the national agenda.

Data integration to trace people's service journey and improve service delivery knowledge.