Don't Walk By ...

Unmet Need in Chronic Severe Mental Health Conditions

Australian National University

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EXECUTIVE SUMMARY

Mental illness is common and affects all Australians either directly or indirectly. The Australian Productivity Commission's comprehensive 2020 review concluded that: "Almost one in five Australians has experienced mental illness in a given year. Many do not receive the treatment and support they need. As a result, too many people experience preventable physical and mental distress, disruptions in education and employment, relationship breakdown, stigma, and loss of life satisfaction and opportunities."

The AIHW estimates that $11.0 billion was spent on mental health-related services in Australia during 2019–20. Of this, state and territory governments spent 60%, the Australian Government 35%, and private health insurance funds and other third-party insurers 5%. Government spending on mental health-related services is estimated to be around 7.6% of total government health expenditure. However, mental illness has a major effect on the Australian economy with the Productivity Commission estimating that "mental illness, on a conservative basis, is costing Australia about $200-220 billion per year. To put that in context, this is just over one-tenth of the size of Australia's entire economic production."

Despite this enormous expenditure there is evidence that a substantial proportion of people with the most chronic severe mental health conditions – schizophrenia, bipolar disorder and severe depressive disorders – do not receive adequate care, if they receive care at all. This is because the care required to manage all aspects of their illness involves not only psychiatric and psychological treatment, but treatment of commonly associated physical conditions and substance use problems. The evidence also shows that provision of secure housing and effective social services is vital to recovery and optimal function for people with these severe conditions.

In this report, we move beyond an analysis of the care that is provided now. **Indeed, current expenditure on mental health care is failing to meet the needs of even those now receiving care.** We review the **unmet needs** of adult Australians with chronic severe mental health conditions and the resources that would be required to meet the needs of every Australian with these debilitating conditions.

People with chronic severe mental health conditions need care not only for their mental illnesses, but for co-existing physical conditions and substance use problems. Yet treatment efforts are unlikely to be successful unless the person receiving care has secure housing, healthy nutrition, and sufficient social support to attend necessary appointments. We have identified a shortfall in the dedicated mental health workforce of 8310 full time equivalents (FTE) across all disciplines, from psychiatrists, to social workers, and all professional groups through to peer workers. The alcohol and addiction workforce is short of 838 FTE staff nationally.

EXECUTIVE SUMMARY, continued…

What does 'met' need look like? There are **three key areas of reform and renewal** that are essential for Australians with severe mental illness:

- **Supported accommodation.**
- **Increasing the number of mental health hospital beds to support acute care.**
- **Mental health workforce expansion, recruitment and retention to provide care.**

In the first instance, **secure supported accommodation is the critical foundation for people to recover and prevent further deterioration and need for additional supports**. The unmet need for supported accommodation is estimated to be approximately 31 000 nationally. Using data from housing projects such as HASI-plus in NSW and The Haven model, we estimate that a building project to meet all demand, extending to the end of this decade, would require expenditure of close to **$6 billion annually**.

The good news is that **supported housing has been shown to be cost-effective through rigorous economic analysis in Australian settings**. Data from contemporaneous Australian supported housing models shows that persons with chronic severe mental health conditions managed in such settings have an up to 74% reduction in the need for community mental health services, reductions of more than 70% in the need for hospitalization, and – if hospitalization is required – reductions of more than 75% in length of stay. These are extraordinary figures.

In a situation where there is a likely shortfall in mental health hospital beds of more than 10 000 nationally, **the need for these beds and the associated mental health workforce would almost be obviated through the positive effects of supported housing alone**.

Also, it would be possible to provide more than 19 million hours of psychosocial support through supported housing. To put this in perspective, the report on unmet need in psychosocial support released by the Australian Government in August estimated unmet need in adults at 12 444 000 hours.

Our estimates – based on government data – suggest that the additional cost of the mental health workforce required to meet all need is approximately **$984 342 000** annually. However, if supported housing models are used then the demand for community services is reduced by approximately 74%. Excluding the workforce of psychiatrists and general practitioners, this would predict **a reduction in workforce requirement outside of the support housing costs fall to approximately $500 000 000 annually**.

It would not be possible for every adult Australian with a severe chronic mental health condition to re-enter the workforce or to contribute fully to the national economy. However, the Productivity Commission's report of 2020 estimated that having every Australian participating as fully as possible in the economy would generate "additional annual benefits of up to $1.3 billion per year as a result of increased economic participation and productivity… and generate savings of up to $1.7 billion per year."

Taken together, our analysis of the magnitude of unmet need for Australians with chronic severe mental health conditions, as well as the cost of meeting all need, is approximately **$6.5 billion annually**. It is likely to generate an additional economic benefit of **$1.5 billion** in real terms annually and reduce other costs to the community of close to **$2 billion annually**, based on the 2020 Productivity Commission analysis and in real terms. These savings are generated, in part, by people with chronic severe mental health conditions to participate more fully in the economy, but mostly by allowing their family members and carers to more fully devote themselves to economic participation and by avoiding the direct and indirect costs associated with providing care. To put these costs in perspective, expenditure on medical care for type 2 diabetes – which is largely preventable – is estimated at more than $2.4 billion annually, with a total estimated cost to the economy of $6 billion annually.

Meeting the comprehensive needs of every Australian affected by a severe chronic mental health condition is likely to pay off handsomely.

Jeffrey Looi, Natasha Robinson, Steve Robson
December, 2024

CHRONIC SEVERE MENTAL HEALTH CONDITIONS

Approximately 2% of adult Australians live with a chronic severe mental health condition. These conditions have a major impact on how people think, how they feel, and on the course of their lives. They also can have a serious effect on their physical health and wellbeing. Many people live with these conditions and not have a significant impact on their lives. However, for some a chronic mental health condition can have a severe effect on their life, education, employment, relationships and social connections. Mental health conditions also bring stigma and discrimination at a level quite different to that of physical health conditions. With the appropriate level of treatment and support people with chronic severe mental health conditions have the potential for recovery and a life that is fulfilling.

SCHIZOPHRENIA

Schizophrenia is a chronic, complex, mental health condition and is the most common psychotic disease. Australian studies have found the population prevalence to be just under five per 1000 adults: it is the most common psychotic condition. The symptoms of schizophrenia typically begin between late adolescence and the early 30s. Onset of schizophrenia commonly is preceded by a period of increasing social withdrawal, loss of interest in school or work, and uncharacteristic behaviour. Schizophrenia is characterized by the presence of hallucinations – hearing voices, for example – and delusions. Delusions are fixed false explanatory beliefs that may include feeling persecuted or threatened and may the basis of how persons with schizophrenia interpret ordinary events. For example, a passing car is believed to be following the person. In addition, people affected by schizophrenia have difficulty expressing emotions and find motivation for the activities of life very difficult. Schizophrenia is commonly associated with substance use such as alcohol, tobacco, cannabis and prescription medications.

Because people living with schizophrenia may have limited awareness of their condition or understanding they are ill, long-term management can present many challenges, but the illness is treatable. Lack of adherence to treatments, and the side effects of anti-psychotic medications, can lead to serious negative consequences including relapses and frequent hospitalizations. Only about one in five people have good long-term outcomes from treatment, and chronic schizophrenia with poor psychosocial function often leads to poor educational achievement, inability to maintain employment, impoverishment, social isolation, and housing instability.

Treatment of schizophrenia is multifaceted and involves not only the management of psychosis with medications and psychological therapies, but psychosocial interventions and, more broadly, social skills training, supported employment and supported accommodation. The earlier the age of onset of schizophrenia, the worse the long-term outlook for people affected. Early onset of the disease is associated with more frequent and longer duration of hospitalization and, overall, a worse life outlook. Of particular concern is that the anti-psychotic medications used to treat schizophrenia have a range of metabolic side effects that lead to glucose dysregulation, weight gain, and cardiovascular disease in the long term.

BIPOLAR DISORDER

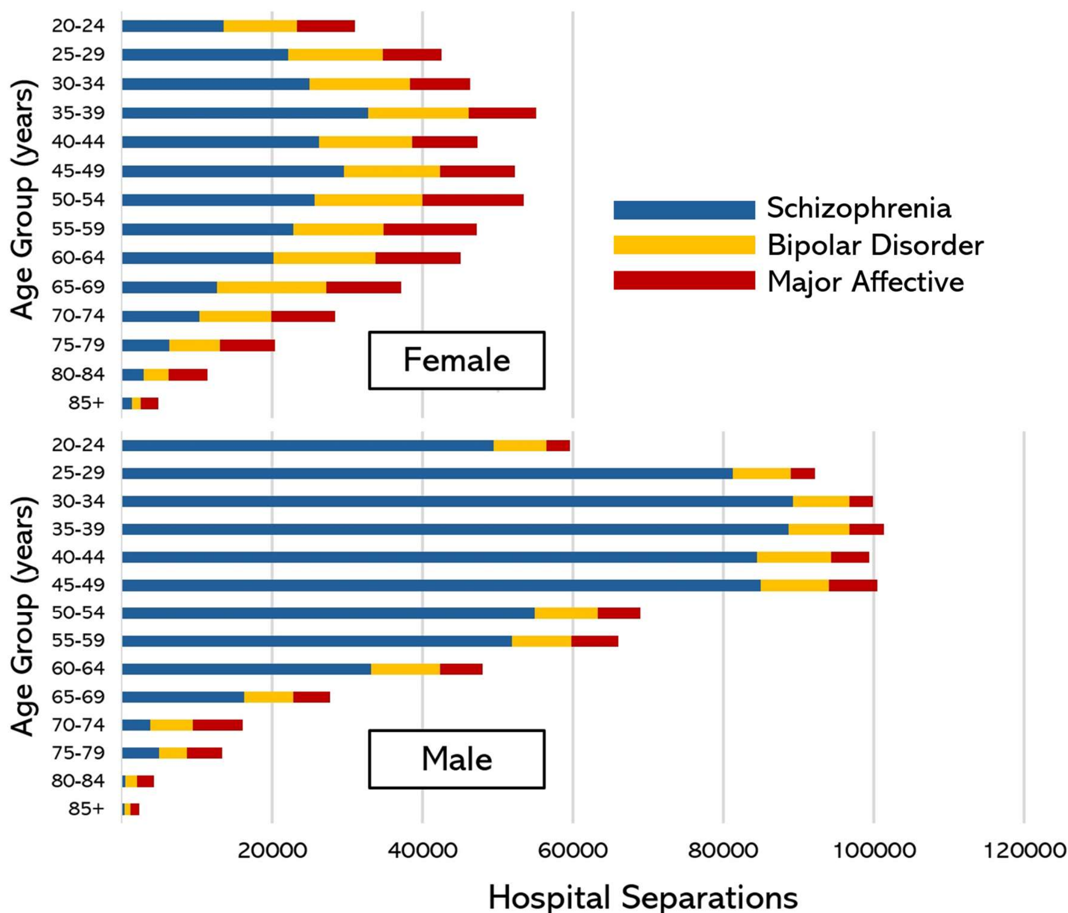
Bipolar disorders also commonly begin in young adulthood. They are characterized by periods of mania and hypomania with psychosis, sometimes depression, but interspersed with periods of relative wellness. The majority of people living with bipolar disorder will experience relapse of their symptoms. In many cases initial diagnosis is delayed because symptoms can be difficult to interpret. Mania is characterized by increased energy, restlessness and racing thoughts. Patients have a decreased need for sleep yet do not feel tired. As episodes progress people will experience irritability, impulsivity and irrationality often with mood swings. These issues can lead to frequent job losses and relationship disruptions, with an increased risk of legal and financial problems. Substance use is common for people living with bipolar disorder. The rate of suicide in people affected by bipolar disorder is as much as 20 times higher than the general population. Treatment of bipolar disorder, like that of schizophrenia, is multifaceted and involves long-term medication, psychosocial treatment, and social support.

PSYCHOTIC & SEVERE DEPRESSION

Psychotic depression remains an under-recognized but common condition in the community. Research suggests that as many as one in six patients with a major depression exhibit psychotic features such as hallucinations or delusions (fixed, false beliefs) that they are guilty or responsible for some major problem not under their control, e.g. they may be bankrupt, or have caused a disaster. People affected by psychotic depression have high levels of suicidality, anxiety and cognitive dysfunction, and are more commonly mature and older adults. These problems can lead to social and occupational dysfunction, and psychotic depression has a poorer course of illness with greater tendency to relapse and higher rates of treatment resistance.

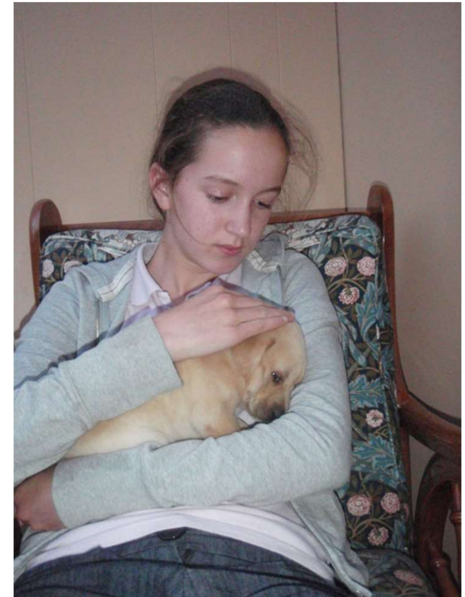
Severe depression affects all aspects of person's life, and they will display persistent low mood, sleep disturbance, loss of energy and motivation, and may withdraw from family and friends at home, and/or stay in bed, neglecting to eat or bathe. People suffering from severe depression may not have psychotic symptoms, but will be uncharacteristically pessimistic, and may think frequently of dying or suicide.

All severe mental illness affects not only the person who is ill, but also family and friends, from whom the person may withdraw, but also seek help and need support. Family and friends may also be distressed by the impact of the person's illness and need their own support.



AIHW data showing the number of hospital separations during 2022-23 by principal diagnosis (schizophrenia, bipolar disorder, and major affective disorder). Note that the number of presentations for schizophrenia declines rapidly after age 64 due, largely, to death of people affected by the condition.

BILLIE'S STORY



Billie* was a young teenager when, after a happy childhood, she was hit by depression so severe that by the age of 15 she was scheduled under NSW Mental Health Act and hospitalised. By the age of 18 she had been admitted to hospital on 25 occasions over the course of 1200 days, before being eventually diagnosed with schizophrenia.

Billie's delusions frequently took the form of a terrifying belief that she was being poisoned. As time progressed, Billie experienced chanting and command hallucinations that became increasingly disabling. The paranoia that came with the illness was at times life-threatening when she would refuse to eat and drink. Billie received electroconvulsive therapy (ECT) to ease these symptoms. Her parents credit it with saving her life. Her schizophrenia is now treatment-resistant but she lives a functional and fulfilling life, albeit with periods of acute ill-health, with the assistance of trusted carers funded by the NDIS, and her dedicated parents.

Billie's experience with mental health care has been characterised sometimes by compassion and care but more often than not by fear and degrading treatment. Experiences of shaming, punishment, force and seclusion has left Billie with a crippling fear of the public health system, but she has a staunch determination to make it better for others.

The first thing Billie would like to see is the practices of seclusion and restraint completely phased out in hospitals. Billie recalls a time when she was put in seclusion for as long as 24 hours. Mental health wards in Australia have small purpose-built rooms within the facility to lock patients in when they are in crisis. It's supposed to keep them safe, but in Billie's case it was her prison. She says the room had nothing more than a blue mattress on the floor, with no bedding, and no bathroom.

"Sometimes I wasn't trusted to even go to the toilet, so they gave me a silver steel bowl in my room, the ones like you see maybe in prison. It all still affects me, it really does."

"You're given medication to calm down and it does work, it does calm you down but then you're left in seclusion for hours, recently as long as 24 hours. The medications helped and it worked, so why am I still in this room?"

Now 29, Billie is picking up the pieces of her life and is a resilient young woman who does an exceptional job of managing her own mental health. Despite the ongoing trauma from her previous admissions she still must regularly navigate a broken system when in crisis. Since she was approved for an NDIS package, life has been infinitely better. Two-thirds of those with a psychosocial disability - like Billie's - who apply for the NDIS are unsuccessful; others with severe acute mental illness are locked out of the scheme completely.

While Billie is one of the lucky few to be granted an NDIS package, it goes little of a way toward solving the problems she knows she will face during her next admission in the public health system. When in crisis, Billie and her parents are faced with a Hobson's choice. They know admitting her to a ward keeps her safe, but are forced to be willing participants in further traumatising their daughter. She will be expected to recover in an environment with chronic overcrowding, delay, and often the presence of violence.

"Every parent, every carer, is in this situation where there's only sets of bad and difficult choices and you've got to try and choose which is the least worst," says father Anthony. "Sometimes it's going and waiting in ED for four days while your daughter lies on a trolley in the recess area. Sometimes it's sending her into acute units, knowing that they are unsafe places, particularly for young women. But staying at home is also unsafe. You just don't know which choice is the least worst."

It's a sentiment mother Bernie also shares. "Australia has got a fantastic healthcare system but there's some obvious gaps in the care for people who are becoming quite unwell but still able to live in the community and don't need to go to hospital. That's just a gap that we've never been able to get any support for, and also that gap between a really acutely unwell situation where there are safety issues, and finding something that's appropriate for young people, that's appropriate for a young woman is very challenging, and I don't think we've ever really found that need well met," she says.

"I think it is simply a case of resourcing mental health care. For all of the time we have been coping with this, that was a constant issue. Acute care wards, mental health intensive care units, they're constantly overloaded or unavailable. We live in a major city, I imagine that it's even harder in rural and remote settings.

"How would I describe the system? I would say that at times it feels like there isn't a system at all," says Bernie. "The system doesn't have the capacity to talk to people, for people to talk things through. The system has the capacity to give medication, to put people into isolation to keep them safe, that's how the system works. Things like that become normalised. Finding time to connect with patients and treat them with respect gets lost. It's a scary place to be."

"It's hard to trust now," says Billie. "The whole experience has just been horrible, it's been heartbreaking. I don't know where I'd be without this NDIS package that I have. I can tell you for a fact I would not be at home right now. I would either be sectioned in a public hospital, or I would be dead."

For Billie, if the healthcare system had been able to provide her early intervention and effective care, she may not have lost so very much. Though Billie doesn't like to dwell on what she's lost, she feels her years-long cycles of trauma, fear and ineffective care was avoidable. Billie's now looking to the future, she's keen to soon join a water polo team. She's worked hard to get to where she is today and credits finding a great team of private healthcare supporters with her success. She just hopes for better treatment for others in her circumstance in the future.

"You admit people and then send them out with not enough care, and then they get more unwell and get sent back, and it's just a constant circle," Billie says. "I don't know if there could have been another way for me. But in the future, I hope for there to be another way."

**Her name has been changed to protect anonymity, although Billie is happy for her childhood photographs to be published*

MENTAL HEALTH AND OUR COMMUNITY

For over 30 years, since the Burdekin Report into Human Rights of People with Mental Illness it has been recognized that mental health conditions are having a profound effect on the Australian community. This realization has led to detailed inquiries by the **Australian Productivity Commission**, the **New South Wales Parliament**, and a **Royal Commission in Victoria**. Key findings from these landmark reports are presented in snapshots here.

PRODUCTIVITY COMMISSION REPORT, 2020

> "Mental ill-health affects **all Australians** either directly or indirectly… Many do not receive the treatment and support they need. As a result, too many people experience preventable physical and mental distress, disruptions in education and employment, relationship breakdown, stigma, and loss of life satisfaction and opportunities."

"The cycling of people in and out of hospital at **great personal cost and cost to taxpayers**, should be addressed."

> "**Housing, employment services and services that help a person engage with and integrate back into the community, can be as, or more, important than healthcare in supporting a person's recovery**. Clinical and community services should be coordinated to create a system of care that promotes recovery, with care coordinators to help people with complex needs."

"Mental illness can impact all aspects of our life: relationships, home life, schooling, work, and social interactions. To help people have lives that are meaningful to them and productive, Australia's mental health system needs to offer the right mix of community and clinical supports for people – noting that for some people, clinical treatment will not be part of their solution. **Recovering from mental illness is about so much more than clinical care; it means rebuilding relationships, strengthening skills, finding and maintaining secure housing and employment**."

ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

"The present system is not designed or equipped to support the diverse needs of people living with mental illness or psychological distress, families, carers and supporters, let along to cope with unforeseen pressures that may arise. Due to system constraints, services are often inaccessible at times when they would make the most difference, and the system largely operates in crisis mode – that is, it tends to react to mental health crises rather than preventing them. **The system is complex and fragmented and, for those who do manage to get into it, difficult to navigate**."

> "Demand has overtaken capacity. **The system is overwhelmed** and cannot keep up with the number of people who seek treatment, care, and support."

"Community-based services are undersupplied. **Many people cannot access treatment, care and support** close to their homes and in their communities."

> "The system has become imbalanced with an over-reliance on medication. Services have come to rely on medication as the main, or sometimes only, treatment people can receive due to **major system-wide challenges such as under-resourcing**."

"Getting help is difficult. People cannot access suitable services, and those who do access the system find it hard to navigate. **People living with mental illness or psychological distress wait long periods and become sicker before they can gain access to services**. Increasingly, a person must exhibit signs of major distress or crisis before treatment, care and support are provided. This means that people do not receive therapeutic supports, such as psychological therapies, and wellbeing supports, such as assistance connecting with the community, at the time when it would make the most difference."

> "**Poverty and disadvantage** make it particularly difficult for people to access services."

"**Services are poorly integrated**. People living with mental illness and other conditions such as poor physical health, disability, or substance use and addiction can find it particularly difficult to gain access to services."

> "Families, carers and supporters are left out. They can feel excluded by the system, and are often left out of engagement that would help them in their caring role. **Many families, carers and supporters require but are unable to access dedicated supports in their own right**."

"Culturally safe services are not always available to Aboriginal communities."

> "Mental illness can be compounded by **housing instability**. People may be forced to move accommodation, or may be uncertain about where they will live. Many people with mental illness also live in substandard accommodation."

"People in the criminal justice system do not get the support they need. **People living with mental illness are over-represented in the criminal justice system**, and the interface between the criminal justice system and the mental health system in poorly coordinated."

> "The experience of poor mental health and wellbeing is different in rural and regional areas. **People living in rural and regional areas can face a number of challenges when accessing treatment**, care and support among them stigma and a lack of local services."

"Dignity is often disregarded and human rights are breached. **Many people who do obtain access to mental health services are not treated with dignity or respect** and are not involved in making decisions about their own treatment, care and support. There is an excessive use of restrictive practices and compulsory treatment."

NEW SOUTH WALES PARLIAMENTARY INQUIRY

"People experiencing mental ill health **often cannot access the mental health services that are right for them**. This can be for a variety of reasons including that services are not available to them, they do not know about them, or their location or cost means they are inaccessible."

> "Social and environmental factors can influence and impact a person's health and health equity. Social factors, collectively termed 'social determinants of health,' include but are not limited to **housing, disability, cultural or linguistic background, literacy and health literacy, gender, sexuality, socio-economic status, and living in a rural or remote area**."

"Delayed access to mental health care may result in: **prolonged distress, deterioration of symptoms, missed opportunities to mitigate against harm and reduce suicide risk, prolonged impact on quality of life and economic participation, and a requirement for more intensive or specialist services in the long run**."

> "Services are not integrated – they are **siloed, fragmented, hard for consumers and carers to navigate**. This can lead to re-traumatization and a reluctance to continue seeking help."

"Staff shortages, increased workloads and burnout are contributing to a **'crisis-driven' mental health system**."

The findings from all of these comprehensive reviews are remarkably similar and paint a picture of a national 'system' for Australians that is **overwhelmed, poorly-coordinated, under-resourced, and not responsive to the needs of hundreds of thousands of people and their families**. A system operating in **crisis mode**. A system allowing so many Australians' clinical conditions to worsen. A system that is having a severe effect on the entire economy. **A system overwhelmed by unmet need**.

SEVERE MENTAL ILLNESS

It is likely that as many as half of all Australians will suffer a mental health condition at some stage in their lives. Indeed, in any given year studies tell us that up to one in five Australians will suffer some form of mental health condition. Fortunately, for the majority of people, these conditions are relatively mild and will resolve.

However, many people will live with mental health conditions such as schizophrenia, bipolar disorder, psychotic depression and other conditions that are **severe, debilitating and usually life-long**.

Much of the modelling used in this report comes from the Australian Institute of Health and Welfare (AIHW) **National Mental Health Service Planning Framework** (NMHSPF), a comprehensive model designed to help plan, coordinate and resource mental health services in Australia. It can be found at www.aihw.gov.au/nmhspf and in this report we use definitions used in that model.

People with **severe mental health conditions** are those who require significant days out of their role, who experience distress or impairment, and who are seen as requiring support from specialized mental health services. For the purposes of modelling, the severe level of mental illness is divided into **severe standard** and **severe complex**.

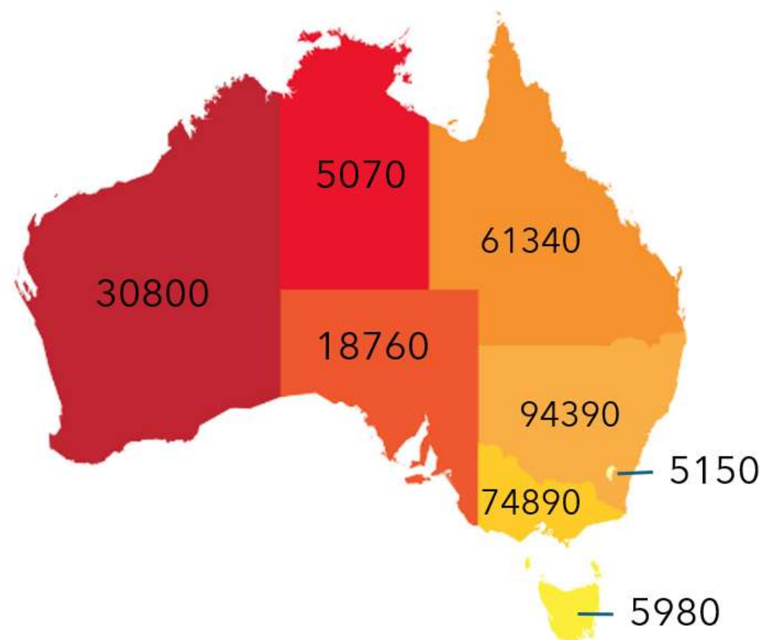
Severe – Complex

People who have a diagnosed mental illness that has a high impact on their day-to-day lives. They have severe, persistent, or episodic mental illness and many experience significant social and environmental stressors.

Severe – Standard

People who have a diagnosed mental illness that has a high impact on their day-to-day lives. They experience lower risks and/or fewer problems with their psychosocial function than those in the severe-complex category.

In this report we consider adult Australians living with severe and chronic mental health conditions. Epidemiological studies estimate that the number of Australians aged 18 to 64 years old with a severe chronic mental health condition was **approximately 296 360 in 2023**. The estimated number of people living with a chronic severe mental health conditions in each state and territory are shown below.



SPECIAL CONSIDERATIONS

FIRST NATIONS AUSTRALIANS

First Nations' Australians – Aboriginal and Torres Strait Islander people – are at special risk of chronic severe mental health conditions. There are many reasons for this situation. Social, historical and economic disadvantage contribute to high rates of mental health problems. These issues are intertwined with stressors such as child removals and incarceration, which in turn lead to higher rates of grief, loss and trauma. **Racism is undoubtedly a factor increasing the rates of mental illness for First Nations' Australians**. The need to address racism as a major determinant of ill health should be a national priority.

For First Nations' Australians health is holistic and can be viewed as a whole-of-life view well beyond the physical. It encompasses broad social, emotional, and cultural wellbeing and includes not only each individual but, more broadly, the whole community. Beyond a strict definition of 'mental health,' the term 'social and emotional wellbeing' is culturally appropriate, recognising the strong connection to culture, land, spirituality, family, and community. It includes social justice, equity, rights, traditional healing, traditional knowledge, and connection to a country.

Unfortunately, the evidence tells us that the rate of mental ill health for First Nations' Australians is increasing. AIHW data show that, between 2009/10 and 2018/19, there was a 52% increase in the hospitalisation rate for Indigenous Australians due to mental health-related conditions (from 19 to 29 per 1,000 hospitalisations). The rate of hospitalisation for mental health-related conditions increased by 58% for Indigenous females and by 46% for Indigenous males. Cohort studies report that, among First Nations' Australians, 6.5% have experienced at least one hospitalisation involving a psychiatric diagnosis by age 23/24. Suicide rates in Indigenous Australians are also very high, especially in males 15-44, and there has been an alarming increase in suicide rates in young females in recent years.

Among Indigenous young people. an alarming 42 per cent have thoughts of suicide and one-quarter have attempted it, according to Australia's first-ever comprehensive dataset on Aboriginal youth mental health and suicide behaviours developed by The Westerman Jilya Institute for Indigenous Mental Health.

"The rate of suicide among Aboriginal children remains unacceptably high. Mental illness has long been established as a causal factor to the escalating incidence of suicides, but this data is showing us that risk indicators markedly differ for Aboriginal youth, which is vital knowledge to have. The absence of national mental health data has significantly hindered any capacity for early intervention, prevention, and, ultimately, for addressing the gap between Indigenous and non-Indigenous youth suicides which is four times greater. The failure of governments to take this basic action to close this gap for Aboriginal youth is unacceptable and disgraceful. If data like this came out from a non-Indigenous child population, there would be alarm bells ringing throughout this entire country. The government neglect in funding services on the complex treatment side into these high-risk regions is outrageous."

Dr Tracy Westerman
Founder and Executive Chair, Jilya Institute.

Australian data reveal a very concerning picture of Indigenous overrepresentation in psychiatric morbidity. By age 23/24 years, Indigenous Australians were diagnosed with psychiatric disorders at a rate over three times that of non-Indigenous Australians (172.16 *v.* 54.12 per 1000). The table below compares the rates of important severe mental health conditions between Indigenous and non-Indigenous Australians.

Condition	Indigenous Australians	Non-Indigenous Australians
Any severe condition	**2.7%**	1.0%
Schizophrenia	**1.8%**	0.3%
Psychotic affective	**1.0%**	0.7%
Psychosis related to substances	**0.8%**	0.2%

INCARCERATION

People with mental illness comprise a disproportionate number of the people who are arrested, who come before the courts, and who are incarcerated. The report of the 2020 Productivity Commission report into mental health, on page 1015 (Table 21.1) provides the following statistics from studies in correctional facilities:

New South Wales	63% had a previous diagnosis of mental illness.
Victoria	37% were allocated a psychiatric risk rating at reception assessment.
Queensland	39% had a previous diagnosis of mental illness.
South Australia	45% of people discharged from prison identified receiving mental health services.
Western Australia	25% had a previous diagnosis of mental illness.
Australia	**40% of prison entrants had previously been told they had mental illness.**

A New South Wales screening program identified 10% of persons appearing before Magistrates' courts as having a mental health condition. Of those identified, 72.6% were found to have a 'severe mental illness.' This would imply that, overall, approximately 7.26% of people appearing before magistrates have a severe mental illness. Of persons found guilty in a criminal court in Australia, 9% receive a custodial sentence.

In the 2022/23 financial year, the Australian Bureau of Statistics (ABS) reported that 491250 people appeared before magistrates in Australia. Using the NSW screening data, this would scale up to 35665 people with a severe mental health condition in the criminal justice system nationally. The NSW screening report found that 35.9% of those identified as having a mental health condition were referred into custodial mental health services, equating to 12800 Australians annually. The prevalence of 'definite' and 'probable' schizophrenia in the prison population is between 4% and 7%, greatly higher than in the general population.

The issue of incarceration and severe mental health conditions is particularly serious for **First Nations' Australians**. Data show that, of Aboriginal people with a mental health condition appearing before the courts, 45% were incarcerated. Australian studies have reported that 11% of First Nations' Australians serving prison sentences have a diagnosable psychotic disorder, with an estimate that almost six percent of First Nations' Australians in prisons have schizophrenia.

Despite the enormous over-representation of people with complex psychiatric illness in prisons, mental healthcare is threadbare. NSW funds less than one full-time special mental health worker position for every 550 prisoners. The recommended number is 11 clinicians for every 550 prisoners.

CRAIG'S STORY

Sydney man Craig had many long admissions in the long-stay mental health facility Rozelle Hospital before the facility was mothballed in 2008. Since then, he has cycled between homelessness and stints in prison. He has little doubt that if he had greater access to community care and secure housing, his life would have been very different. "**No one gives a fuck about me to be honest**," says Craig. "I haven't had any help from anyone. No one has assisted me at all. It's hard to trust anyone." Undeniably, there were horrors within the hospital's walls in a model of care that stripped patients of autonomy and subjected them routinely to restraint and seclusion that was hardly therapeutic and often cruel. But for many of those cast adrift as the long-term mental hospitals shut down, life outside of the institutions' walls has offered little comfort either. Craig spends most of his days on the streets, and rarely sees a doctor. But he feels lucky to have made it to 70, unlike many of his compatriots living rough.

"I think our use of prisons are as kind of asylums. It's the biggest mental health service in the state for psychotic illnesses. But the trouble with prisons is it's a revolving door. Everyone gets discharged or released from prison at some stage, and then you're absolutely back to square one. It's a very poor interface."

Professor Olav Nielssen
Psychiatrist at St Vincent's Hospital
Professor of Psychiatry at Macquarie University

"The release of people from prison is probably one of the worst-managed services I've ever come across. People maybe get two nights in a hotel to then follow up with a GP, and it all falls apart relatively quickly. Their mental health deteriorates, their substance use escalates, and they often just end up right back in prison. And if people complete their whole sentence, they don't get any support at all upon discharge."

Dr Yvonne Bonomo
Director of Addiction Medicine, St Vincent's Hospital, Melbourne

"Since deinstitutionalisation, people with severe mental illness have been neglected and marginalised, and it's like a new dark era where people aren't getting their needs met with the highest level of acuity. They've ended up in prisons. They've ended up dying prematurely, they've ended up dealing with severe substance use, they've ended up on the streets."

Associate Professor Gary Galambos
Medical Director of Uspace, the youth and young adult mental health service at St Vincent's Private Hospital in Sydney

MIGRANTS AND REFUGEES

Data regarding the prevalence of chronic severe mental health conditions in migrants to Australia are difficult to obtain. AIHW data reveal that mental health conditions, overall, appear to be less common among humanitarian entrants compared with the rest of the Australian Population. After standardising for age, self-reported mental health conditions were 50% lower for humanitarian entrants than the rest of the Australian population. Rates of antidepressant prescriptions and GP mental health management plans were also lower for humanitarian entrants than the rest of the Australian population.

However, a study of young people presenting to an emergency psychosis treatment unit in the north-west of Melbourne revealed that approximately 25% of patients aged 16 to 25 years were first-generation migrants. When prevalence estimates were made the highest risk groups were from central and west Africa, followed by southern and eastern Africa, and north Africa. Compared to the Australian-born population, persons from South-East Asia, China, and Southern Asia had lower rates of psychosis.

CO-MORBIDITIES

People living with chronic severe mental health conditions commonly have associated physical illnesses. Physical illnesses that occur at that same time as mental health conditions are known as co-morbidities. The presence of co-morbidities causes a range of important problems for people, and they drive reductions in the quality of life (QoL), can worsen mental health conditions, and is strongly associated with early mortality and severe illness. In particular, the presence of physical co-morbidities places a person with a mental health condition at higher risk of needing hospitalization. Typical co-morbid conditions include chronic lung disease – often associated with smoking – as well as diabetes and cardiovascular conditions such as hypertension, worsened by overweight and obesity. Liver disease is also common due to substance use and chronic hepatitis infection. In many cases, the metabolic effects of anti-psychotic medications cause co-morbid physical conditions. Epilepsy is not uncommon and often not well controlled.

It is estimated that between 50 and 80% of people with chronic severe mental health conditions have a physical co-morbidity, making such a complex clinic problem almost the standard condition. Problems such as poor hygiene, alcohol and other substance use, lack of access to medical care, poor nutrition and lack of physical activity, and poor adherence with medications all confer a worsened prognosis for physical conditions. Unfortunately, satisfactory ongoing and coordinated treatment of co-morbid conditions is very often neglected and this leads to worsening of the physical conditions. Access to non-mental health clinical care is commonly compromised with resulting healthcare inequity. The destabilizing effects of physical co-morbidities is associated with higher chances of early mortality. There is commonly a division or 'siloing' with physical illness treated by a general practitioner or other specialized hospital-based medical clinic. This increases the number of clinical contacts required by patients with severe chronic mental health problems. The accessibility and affordability of GP consultations and care then becomes a major factor on the control of physical illness.

"Housing is actually the biggest issue for really vulnerable people with mental illness and substance use disorders that we have no choice but to send back out into the street. There really isn't a lot of hope for them to be able to engage in services because they're just trying to survive. Basically they're given $300 every every six months through a housing service for health care and once they've used that, they have to self-fund and it's just impossible. We need to take a hub model and put it in the community where you had psychiatrists, you have addiction medicine therapists with lived experience workers, and nursing stuff that can address people's whole presentation, not just their mental health, not just their addiction, but also their physical health. People will often come in, and actually they've got pneumonia, or they've got a gangrenous toe that actually needs treatment or they've got untreated diabetes and we're able to address all those issues in the one place. If you could take this model into the community and have all the resources in one place then people could utilise the whole gamut of

Dr Yvonne Bonomo

Director of Addiction Medicine, St Vincent's Hospital in Melbourne

SUBSTANCE USE

There is a well-recognized relationship between mental illness, particularly severe mental illness, and substance use. This relationship is complex: while mental illness makes a person more likely to use substances, similarly substance use can be a contributing factor, at least for the initial symptoms of mental illness. People with a mental illness are more likely to use alcohol, to smoke tobacco, and to use illicit substances such as cannabis. Studies suggest that about 50 percent of individuals with severe mental illnesses will develop a substance use disorder at some point during their lives. Dependence is common, with almost half of people with a severe mental health condition exhibiting current substance abuse or dependence. **Unfortunately, the use of drugs and alcohol by persons with severe mental illnesses can have a range of often-severe adverse impacts on the course of mental illness and psychosocial functioning**. Substance use can further affect compliance with treatment both of mental and co-morbid physical conditions, leading to a poorer prognosis overall. Further, rates of use of acute services and hospitalization markedly increase. Separation of specialised alcohol and other drug services from both mental and physical health services adds a great deal to the complexity of providing care.

Mental ill-health and substance use frequently go hand in hand, yet there is a virtual complete fragmentation around the nation of mental health and substance abuse support services. St Vincent's Hospital in Melbourne is one of the rare institutions that has a dedicated unit integrated into its emergency department to cater to around 6,800 people who attend the ED each year with mental health and alcohol and other drug emergencies. The Mental Health, Alcohol and Other Drug Hub incorporates a six-bed short-stay like unit and two quiet interview rooms, as well as a communal space where carers and patients can spend time together in a calming, comfortable, secure and safe environment.

"People turn up to the emergency department desperate for detox. But as detox beds are really limited, and it's even harder to organise long-term rehab. We're all aware there is an enormous need. So turning those people away and saying, 'you have to wait', I mean, it's tragic. It's just awful. Someone comes in with enormous courage seeking mental health. And when the bed becomes available, they may be lost out in the atmosphere. Accessing psychology, psychiatry, GPs in the community is very difficult. Getting a bulk billing psychologist is virtually impossible in Melbourne. So they're not able to access the support early on, and by the time we see them everything has escalated, and they're saying 'I need help, but I can't afford it, I can't access it'. We just need to have more resources for people in the community so that people are not getting to breaking point."

Lisa Close,
Coordinator, St Vincent's Hospital Melbourne's Mental Health, Alcohol and Other Drug Hub

PATRICK'S STORY

Patrick was a regular kid. He emerged a well-adjusted teen following a happy childhood and a flourishing teenage academic life in one of Adelaide's top private schools. A coveted place in a law and economics degree lay ahead. But it was all laid to waste in eight years as Patrick transitioned to adulthood. "We all thought that he was a magnificent rocket just resting on the launchpad, ready for launch," his father Andrew says.

The first inkling that something was not right came in Patrick's first few months at university. While his peers languished in the sun on lecture breaks on green university lawns, the teenager holed himself up in his bedroom at home with the curtains drawn. Within four months, he had dropped out of university, and a couple of years of "drifting" between casual jobs amid increasingly poor mental health combined with cannabis use culminated in eventual crisis in 2019 when Patrick's beautiful mind descended into psychosis. An involuntary hospital admission followed after a psychiatrist attended Patrick's home with three police officers and nurses. Patrick was scheduled, handcuffed and forcibly injected.

Sadly, what came next was nothing short of "rolling chaos". After five hospitalisations Patrick received an eventual diagnosis of schizoaffective disorder. After every hospital discharge, Patrick's substance abuse continued, but there was no integration whatsoever of drug and alcohol services with the mental healthcare system. This is a problem nationwide.

Like so many people with severe mental health problems, Patrick experienced years of insecure housing and homelessness. The hospital system was a "revolving door": Patrick would sometimes spend as long as 72 hours in the emergency department, an environment of 'utter chaos", and was repeatedly discharged from inpatient wards often after only a day or two when still clearly unwell, walking out of the ward in a manic state with only a garbage bag containing his few clothes, and nowhere to go.

Patrick's young adult life is a vivid illustration of the ineffective nature of Australia's mental health system and its failure to coordinate with either substance abuse or vital housing services. The tragedy is that his parents could see what was coming as they desperately tried to get help for their son.

"His mother was the first one to say it out loud," Mr Leunig said. "'She said to me at one point: 'you know, we're going to lose him'."

Mr Leunig's despair at his son's plight was acute, but the business consultant also became increasingly aware over time of the sheer fiscal waste seen in the microcosm in his son's case.

"I calculate that the total cost of supporting Patrick from August 2019 to March 2024, including police, ambulances, hospitals, community health care and Guardianship exceeded $750,000," Mr Leunig says. "This is serious money but it was mainly spent in a 'reactive' fashion, akin to 'the ambulances parked at the bottom of the cliff'."

"The very idea of throwing someone who is still suffering a degree of mental distress into a taxi with two nights in a motel is disgraceful.

"It seems to me that even acute treatment in mental health hospitals is the administration of medication – a few minutes a day – and then a lot of waiting and observation. Continue the medication or tweak it. Rinse and repeat. The inpatients have little if anything to do."

"The hospital has merely 'passed the parcel.' It then creates a crisis for the people charged with finding accommodation for that person."

By late last year, Patrick had finally gained a place in a rare supported-accommodation facility, at *Common Ground* in Adelaide. He was the happiest he had been for years.

But on Easter Monday, 2024, Mr Leunig received the call he had been dreading, from Port Adelaide police. Patrick was dead. Just when he had finally gained some stability, he had overdosed on methamphetamine in his room. By his father's best guess, it was accidental.

"Patrick had been running along a tightrope for years," Mr Leunig says. "And now he'd fallen just when I felt like there were some green shoots.

"But I think that we'd all had a feeling that this day may come. He'd largely been 'lost' to us for a number of years. We all held out hope that he'd receive care and that we could repair and re-engage. Where there's life, there's hope but now there was no life and no hope.

"As a father - I'm heartbroken. As a citizen and a taxpayer, I'm appalled.

"We don't blame 'the system' for Patrick's death. But we felt that failings in the system increased and prolonged his trauma and that ultimately made his life and ours much more difficult than it needed to be and the path to wellness and 'living his best life' that much harder."

PSYCHOSOCIAL SUPPORT

The Productivity Commission report of 2020 explained that **psychosocial supports** are "… a key facilitator of recovery, can help alleviate some risks of illness relapse and support people as they develop skills to self-manage the effects of variations in their mental health. Services typically provided under this label include respite services, building social skills and relationships in a culturally supportive way, assistance with transport, tenancy or household management and finances, and coordination and support in complying with clinical treatment needs."

Psychosocial supports are non-clinical and recovery-oriented services, delivered in the community and tailored to individual needs, which support people experiencing mental illness to live independently and safely in the community. Typical components of psychosocial support are aimed at assisting people with chronic severe mental health conditions to:

- Manage **daily living skills**.
- Obtain and maintain **housing**.
- Identify client needs for **other services** (such as the NDIS, alcohol and other drug treatment services, and clinical care), connect with and maintain engagement with these services.
- Socialize, build and maintain **relationships**.
- Engage, and maintain engagement, with appropriate **education** (including vocational skills) and **employment** opportunities.

Psychosocial support can take a number of forms, and commonly people with severe chronic mental health problems will need differing and multiple forms of such support. Recognised models and forms include:

- Individual support and rehabilitation.
- Individual peer work, group-based peer work, group carer support services.
- Family support services.
- Day respite care.
- Flexible respite care.
- Day program teams.
- Evidence-based physical therapies and structured psychological therapies.

EVIDENCE-BASED MODELS OF CARE IN SCHIZOPHRENIA

Schizophrenia has a chronic and debilitating course, and unfortunately the current pharmacological interventions are only modestly effective. Schizophrenia is one of the world's 20 top causes of disability, and **between 70% and 90% of persons living with schizophrenia have employment and housing difficulty**. The requirement for broad psychosocial ways helping and caring for people living with schizophrenia means that both pharmacological and non-pharmacological approaches are usually required. The evidence around these differing types of treatment are summarized, briefly, here.

CASE MANAGEMENT

Case managers try to understand clients' needs, develop a care plan, connect them with services, and assist patients maintaining regular engagement with psychiatric services.

Case management has been shown to be significantly more effective than outpatient care alone – however it has not been shown to improve patients' clinical condition or hospital readmission rates. It also has been assessed as having no significant impact on healthcare costs.

INTENSIVE CASE MANAGEMENT

Intensive case management teams deal with smaller caseloads – usually less than 20 patients. They are high input, often operating providing 24-hour accessibility, with a particular focus on medication compliance and 'assertive outreach' with 'uncooperative clients.'

Intensive case management usually a multidisciplinary team comprising medical and non-medical members. It has been shown to be useful for people with severe mental illness living in the community who require frequent hospitalization.

Intensive case management has been shown in trials to improve patients' symptoms and social functioning, to reduce emergency hospital visits, but with only a small effect on employment and housing stability.

ASSERTIVE COMMUNITY TREATMENT

Assertive community treatment is a team-based, low caseload and high-intensity model that provides all care at home. Teams provide holistic care that incorporates illness management, medication management, housing support, assistance with finances, and daily living needs such as shopping and transport.

There is level one evidence that assertive community treatment models reduce hospitalization and re-hospitalization, and evaluations have proven cost-effectiveness in management of schizophrenia in the community. The assertive model also has been demonstrated to reduce substance use, homelessness, and criminal acts by clients.

CRISIS INTERVENTION MODEL

Crisis intervention models are team-based and provide 24-hour availability. Their purpose is to respond to 'crises' by assessing the client's status and providing all necessary assistance with a view to keeping people out of hospital. This is a common model of community care and has been shown to reduce hospitalization.

Each of these models of care – models aimed at providing evidence-based care in non-institutionalized settings – requires **resourcing, funding, and staffing**. The models are predicated on the availability not only of psychiatric and psychological care, but of non-mental health medical care for co-morbidities, and appropriate alcohol and drug services. They also will rely on adequate housing and financial support for the patients for whom they provide services.

For these reasons, unmet need in the care of Australians with severe chronic mental health conditions can only be addressed with an increased workforce not only in mental health care, but physical health care and alcohol and other drug services. It also will require adequate and, for most patients, supported housing. This report now will examine unmet need from these perspectives.

NEED – AND UNMET NEED

One way to measure patients' access to care is to estimate the proportion of a group that has unmet need. The definition of 'unmet need' we use in this report is based on that of Rosenberg and colleagues (2023):

"The presence of healthcare needs for which people do not or cannot receive quality healthcare."

Whether a patient receives healthcare of appropriate quality depends on many factors. In the first instance each person's health literacy, expectations and preferences, current state of health and individual values all play a role. However social determinants play a key role in access and issues such as the affordability and quality of care, as well as supply side constraints, all affect how well need can be met.

Ultimately, it is the response of policy makers to evidence of unmet need that determines its effect on patients. When the need for care involves severe mental health conditions, unmet need has serious adverse effects across multiple domains. In the first instance, poorly- or untreated psychosis leads to more severe symptoms and higher rates and longer duration of hospital admission. Further, poorer cognitive function worsens social outcomes, is associated with more severe physical co-morbidities, injury, substance misadventure, and suicide. For these reasons, ensuring that every Australian with a severe chronic mental health condition receives the best possible care should be a high priority for our health system.

Effective care of patients with chronic severe mental health conditions is complex and multifaceted. It involves not only medication but a range of psychological treatments, as well as psychosocial care. Importantly, because such a high proportion of patients have co-existing physical conditions as well as

MEETING UNMET NEED

A WORKFORCE ADEQUATE TO MEET DEMAND

Because of the complexity of managing people living with chronic severe mental health conditions, an adequate workforce to meet demand will be required not only for the mental health aspects of provision of care, but also for physical health needs and alcohol and other drug services.

Typical need for a stable patient with a severe chronic mental health condition managed as an outpatient is 30 minutes of psychiatrist time every three months. For a psychologist, 30 - 45 minutes every three to four weeks would be typical. It is important to remember that both psychiatrists and psychologists will be managing not only patients with chronic severe mental health conditions, but a large number of patients with a range of other mental health conditions.

The **National Mental Health Workforce Strategy 2022-2032** has examined the need for Australia's overall mental health workforce and developed the Strategy based on outputs from the NMHSPF.

> "As the demand for mental health support and services increases, **there is an urgent need to grow and create a well-rounded and responsive mental health system across Australia**, supported by an appropriately skilled and contemporary workforce to meet the needs of all Australians."

The modelling reports a 32% overall shortfall in the mental health workforce compared to targets, with the shortfall likely to increase to 42% by 2030. Of concern, the availability of mental health staff is generally lower in more remote areas.

The more detailed *ACIL Allen Workforce Report* to the Commonwealth Department of Health, published in 2022, contains pre-pandemic statistics. Workforce shortfalls and associated costs in 2023 figures, as updated, are shown in the following table revealing **an annual cost to fill the shortfall of $927611950**.

		FTE			
Role	**Actual Size (2019)**	**Target**	**Shortfall**	**Cost/FTE ($, 2023)**	**Total (2023)**
First Nations' Health Worker	53	143	90	57700	5 193 000
General Practitioner	2671	3102	431	128125	55 221 875
Peer Worker	315	1269	954	54400	51 897 600
Registered Nurse	16644	19347	2703	74200	200 562 600
Occupational Therapist	1738	2227	489	67700	33 105 300
Psychologist	12981	14292	1311	81870	107 331 570
Psychiatrist	2861	5093	2232	212500	474 300 000
Social Worker	2401	2079	surplus	--	
					$927 611 950

"I call it moral injury, psychiatry. This is what we operate in, in this country. We're all crying here. If you're in cancer care, you know exactly what's going to happen. If I'm an oncologist I can feel safe in the knowledge that I'm delivering evidence-based care to all my patients every single day. But no psychiatrists, very few psychiatrists in Australia, I think, would be able to say the same thing."

Dr Angelo Virgona,
Board, Royal Australian and New Zealand College of Psychiatrists

"At this point in time, there's a sense of deep demoralisation amongst most of my colleagues, where they feel that the battle's kind of lost. There's been a huge mutiny of my colleagues out of the system, people who were passionate about the public sector, they feel that that the system is like a conveyor belt, and they're being treated like technicians. The culture has become managerial, it's all about short-term economic efficiency. But there's nothing cheap about having someone in hospital for 700 days in an acute unit. The system has become so crisis-driven, that you can't be therapeutic in a system like that. Basically, you become part of an abusive system because it's crisis focused. And the only way that you can tolerate working in a system like that is part time."

Associate Professor Gary Galambos
Medical Director, Uspace, the youth & young adult mental health service
St Vincent's Private Hospital in Sydney

The Commonwealth Department of Health and Aged Care *Report on Unmet Need for Psychosocial Support* has found that, outside of the NDIS, 20400 people aged 12 – 64 years received psychosocial support through Commonwealth, state and territory governments. Within the NDIS, 28 000 people in the age group received support.

Overall, then, the estimate was that in 2022-23 for adult Australians – those aged 18 to 64 years – 12 444 000 hours of psychosocial care were unmet. To estimate the cost of meeting these needs, it is possible to use audit data from Australian state psychosocial support programs. The South Australian 2021/22 average program costs to provide individual peer support in the adult age group was $96/hour, and for individual support/rehabilitation the figure was $74/hour. The hourly cost of the NSW CLS was $80.71/hour.

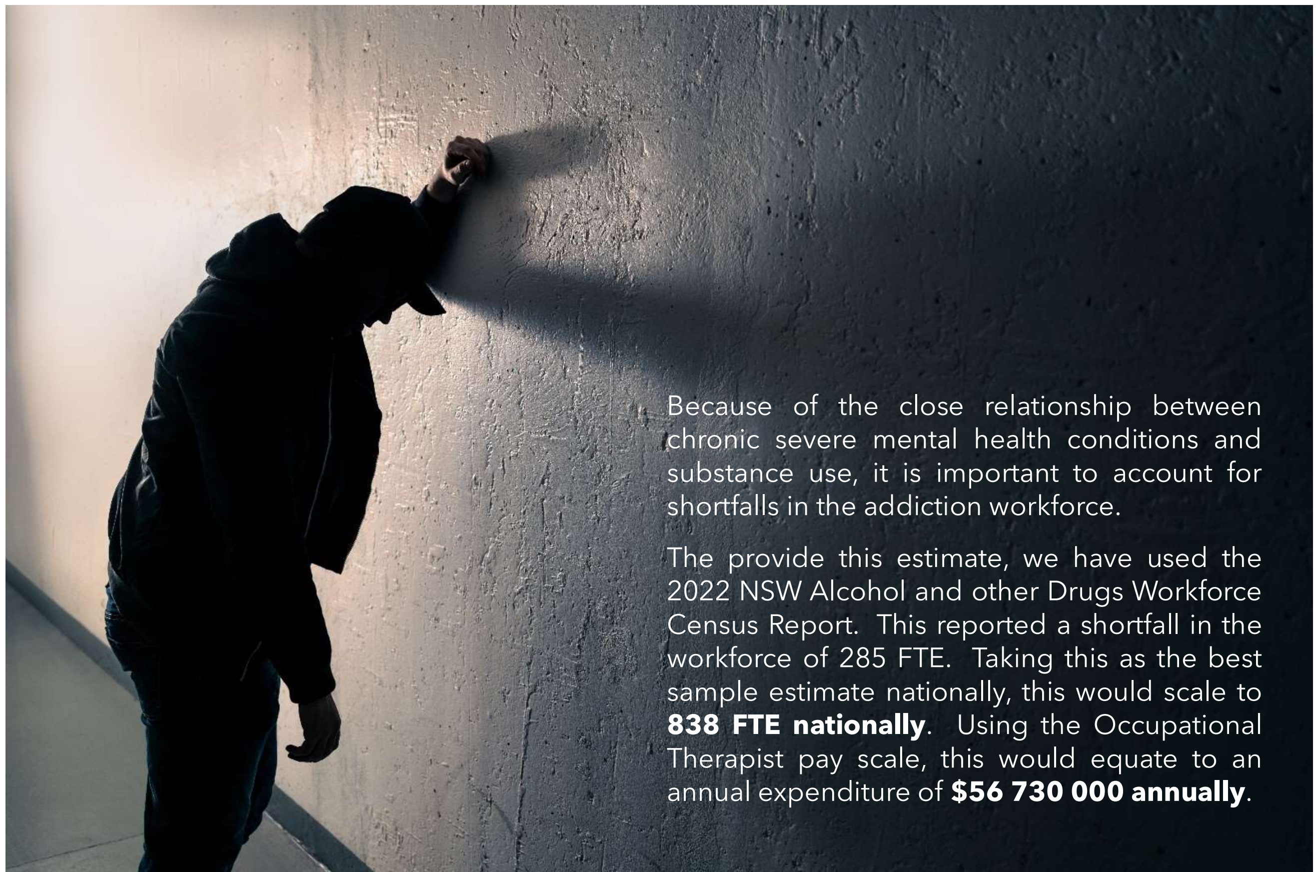
Using these data to underpin estimates of the cost of unmet psychosocial support, the figures range from a low annual estimate of **$920 856 000** (using the SA hourly program figure) to a high annual estimate of **$1 194 624 000** (using the SA rehab figure), with the median figure of **$1 007 964 000** (using the NSW state CLS average). **These figures correlate very closely with the estimates of salary costs for mental health workers in the table above**.

While about a quarter of those with severe mental illness and associated psychosocial disability have NDIS packages, **about 75% are locked out of the national disability scheme**. Those in the scheme receive frequently generous support packages, sometimes amounting to close to $1 million a year, while psychosocial services are virtually non-existent for around 230,000 other people with severe mental illness.

"We have a number of complex patients on the NDIS who are in Supported Independent Living. And it's a really expensive model, to have one person being serviced by multiple carers throughout the day and receiving multiple services. And I think it would be beneficial and that there would be a large cost benefit if we could have a range of services providing support to these long-term patients in one area, one facility."

Dr Yvonne Bonomo
Director of Addiction Medicine, St Vincent's Hospital in Melbourne

ALCOHOL AND ADDICTION WORKFORCE



Because of the close relationship between chronic severe mental health conditions and substance use, it is important to account for shortfalls in the addiction workforce.

The provide this estimate, we have used the 2022 NSW Alcohol and other Drugs Workforce Census Report. This reported a shortfall in the workforce of 285 FTE. Taking this as the best sample estimate nationally, this would scale to **838 FTE nationally**. Using the Occupational Therapist pay scale, this would equate to an annual expenditure of **$56 730 000 annually**.

UNMET NEED IN HOUSING

Housing is the foundation for mental health recovery, with a strongly bi-directional relationship. People with mental health conditions are more likely to experience housing insecurity and homelessness, and housing problems can lead to mental health conditions. In their 2023 submission to the Australian Government Department of Social Services consultation, Mental Health Australia make the point that:

> **"Appropriate housing is a critical foundation for people to recover and maintain mental health and can prevent further deterioration of mental ill-health and reliance on other services."**

Supported Housing Community Models have undergone economic cost-effectiveness modelling. For example, the Doorway program is a Housing First (HF) program that provides support to people with serious and persistent mental illnesses receiving care within Victoria's public mental health system and who are precariously housed. By "precariously housed" is meant housing where there is imminent risk of the person becoming homeless, in contrast to the person being absolute homeless. The program was found to be cost-effective – in line with other international studies – with the added benefit of showing positive benefit in clinical outcomes for patients.

The integration of mental health and psychosocial support with housing has been shown to be effective not only in improving outcomes for patients, but also in terms of cost-effectiveness. Supported housing models integrate housing, psychosocial and mental health support services. Evaluations have demonstrated that supported housing models sustain long-term tenancy, assist recovery from acute exacerbations of mental health conditions, and reduce inpatient hospitalizations.

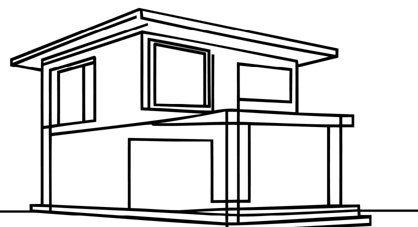
To estimate the volume of need for housing we used estimates from the Australian Institute of Health and Welfare (AIHW) Specialist homelessness services annual report 2021-22. The AIHW estimate for unmet need for long term housing for Australians with a current mental health condition was 30953. **This was *exclusive* of unmet need in emergency accommodation (13129) and medium term/transitional housing (20587).**

Since these were 2022-23 data we have rounded up to 31000 patients as a conservative estimate. Data from Mind Australia/The Haven Foundation show that approximately 50% of patients with schizophrenia are, after evaluation, found suitable for supported group accommodation services. The remainder, for various reasons, are unsuitable for a group setting and are considered best suited to supported individual accommodation.

SUPPORTED GROUP HOUSING (HAVEN MODEL)

Extrapolating from the Haven model data, 16000 individuals thus would be suitable for Haven-type supported communal setting. To obtain cost estimates we used data supplied by The Haven Foundation/Mind Australia. For this model, start-up costs were estimated at $154900 as a one-off 'set-up' cost in the first year, with recurrent annual costs. This model provides long term housing and associated psychosocial supports for people with severe and enduring mental health illness. Construction is approximately $8 million with a 12 to 18 month build time.

Residents have their own self-contained apartment with private kitchen and bathroom facilities, located within a block of units that offers shared communal facilities to provide space for social interaction. 24/7 psychosocial support is provided. Annual costs per occupant for The Haven Model is $119222.



SUPPORTED COMMUNITY ACCOMMODATION (THE HASI-PLUS MODEL)

The NSW Government analysis of Community Living Supports (CLS) and the Housing and Accommodation Support Initiative (HASI) are used to estimate representative costs of providing care to individuals outside of a supported community housing model such as The Haven. The average cost is $186011 per client annually.

For this analysis, we assume approval and construction over a five-year timescale [beginning in 2026 and continuing through to 2030] and assume a 3% inflation prediction annually to 2030. Using the start-up and established costs, modelling results are shown below:

	Haven Start-up	Haven Established	HASI-plus model
2024-25	-	-	16000 x $191580 **$3 065 280 000**
2025-26	3200 x $164335 **$525 872 000**	-	12800 x $197330 **$2 525 824 000**
2026-27	3200 x $169265 **$541 648 000**	3200 x $126 480 **$404 736 000**	9600 x $203250 **$1 951 200 000**
2027-28	3200 x $174340 **$557 890 000**	6400 x $130 275 **$833 760 000**	6400 x $209350 **$1 339 840 000**
2028-29	3200 x $179570 **$574 624 000**	9600 x $134185 **$1 288 176 000**	3200 x $215630 **$690 016 000**
2029-30	3200 x $184960 **$591 872 000**	12800 x $138210 **$1 769 088 000**	-

For the estimated 15000 clients in supported housing in a rental environment using existing housing stock – the HASI-plus model – estimates are as follows:

2024-25	15000 x $191580 **$2 873 700 000**
2025-26	15000 x $197330 **$2 959 950 000**
2026-27	15000 x $203250 **$3 048 750 000**
2027-28	15000 x $209350 **$3 140 250 000**
2029-30	15000 x $215630 **$3 234 450 000**

Combining these two sets of supported accommodation for **both of the supported accommodation groups** yields:

2024-25	**$5 938 980 000**
2025-26	**$6 011 646 000**
2026-27	**$5 946 334 000**
2027-28	**$5 693 066 000**
2029-30	**$5 595 410 000**

SHEREE'S STORY

Life has never been better for 42-year-old Sheree Barton. The Melbourne woman experienced many years of insecure housing before moving into a private apartment within a supported living home in the western suburb of Laverton built by the Haven Foundation, a charity which is a subsidiary of mental health service provider Mind Australia.

The residence contains about 16 private apartments, each of which has its own kitchen, living room, bathroom, laundry facilities and outdoor area, built around beautiful gardens and a shared living area with a large communal kitchen opening out onto a large backyard.

Having her own permanent residence with 24-hour support from health and social workers has transformed Ms Barton's life.

"I walked in here for the first time and I just thought: 'this is my home'," Ms Barton says. "My health has improved. My mental health is fantastic now. I was getting sick all the time before, but now my health is just really stable.

"I take my medication, go to appointments, I work with the staff here on my goals, and communicate a lot with them. If I'm hearing voices, I speak up. I'm pretty aware now. I've got a lot of insight. I know when I'm getting unwell. I've got my tool kit - I listen to music, go for a walk, do some cooking. And the staff are available all the time."

The Haven Foundation was formed in 2006 by a group of families, friends and carers of people with mental ill-health, and has now built 10 long term housing residences for people with psychosocial disability in Melbourne and regionally, with 17 more currently being built. Three homes are also in construction in NSW and one in Adelaide. Secure housing is recognised as a key pillar for recovery from mental ill-health, and having health and social care provided in-house is crucial for people like Sheree, who live with trauma from past experiences, not least in the mental health system.

"It was hard before I moved here, I was struggling to cope," Ms Barton says. "I had to rebuild my life again. I've had good times and bad times. The experience of being a patient is pretty scary. People are violent, they're yelling and screaming. It was traumatising."

The Haven model operates like a cooperative, where residents contribute a portion of their NDIS core funding to the Mind Foundation which then delivers 24/7 shared support to residents which can also include one-on-one support based on individual needs. Support provided to residents includes help with the activities of daily living, personal care support, medication management, budgeting, community access and peer support. Residents pay 30% of their disability support pension plus their Commonwealth rent assistance towards their own rent. It's a far cry from the private supported boarding house market, which sprung up after the closure of long-term mental hospitals. Many residents in those boarding houses, some of which operate well and others which are places of squalor, pay between 75 and 95 per cent of their pension to landlords, and receive minimal support other than medication management and daily cleaning of bedrooms. Such a market has flourished because there is simply nowhere else for many with chronic severe mental health conditions to go.

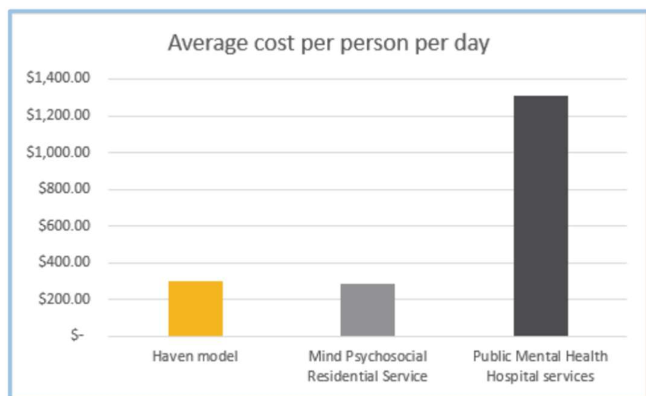
The Haven model has proved not only life-changing for residents: it results in efficiencies for the NDIS and the health system as a whole. A Haven home for an NDIS participant is less than half the cost per year of the national average cost of housing for an NDIS participant in supported independent living. The average healthcare costs for a resident in the Haven model is a little over $200 a day per person, compared to a cost to taxpayers of $1300 a day for a public mental health hospital inpatient.

Now that her health is on a positive trajectory, Ms Barton has been able to focus on gaining greater independence. She has been volunteering at Vinnies and has just started a paid position there two days a week. It gives her some precious spending money to indulge one of her hobbies - purchasing fashion items.

"One of my goals is working on budgeting," she says. "I'm getting some money, getting new skills, meeting new people. I'm a lot happier now."

UNMET NEED IN ACUTE HOSPITAL CARE INFRASTRUCTURE – HOSPITAL BEDS

For people living with chronic severe mental health conditions, the **alternative to homelessness is commonly acute contact with, and admission to, public hospitals**. The cost of provision of public hospital care and inpatient accommodation is high compared to community options. Estimates from Mind Australia [The Haven model] show the following comparison:



The audit of the NSW community support programs found that for people who stayed in CLS accommodation, a 10% reduction in the need for community mental health services in the first year was demonstrated, and an additional 63.7% reduction if remained for more than one year. Reduction in hospitalization due to mental health conditions by 44.8% in first year, and a FURTHER 29.2% in year two. Average decrease in hospital days from 49 days to 12 days after two years.

Capacity in mental health beds and inpatient services in Australia is severely constrained, yet there always will be a need for specialized inpatient hospital beds to allow treatment of persons with severe chronic mental health problems who experience relapse or crisis. According to the methodology of Allison and Bastiampillai (2015), the OECD average for psychiatric inpatient beds is 71 per 100000 of population. This would predict a need for 17750 beds nationwide for Australia. Unfortunately, Australia had only 7000 specialised mental health beds in 2022. **This would imply a shortfall of 10750 specialized mental health beds nationally,** at least compared to the OECD average. To estimate the flow-on benefits of supported accommodation to the public hospital system, we have used AIHW data to provide estimates of the effects of meeting currently unmet need.

Published AIHW data for the financial year 2022-23 were obtained for hospital contact where the principal diagnosis was a severe chronic mental health condition – we combined data for **schizophrenia**, **schizotypal** and **delusional disorders**, **severe bipolar** and **severe depression with psychosis**. When we considered inpatient hospital admission [greater than day-only presentations] and pooled these across these diagnostic groups we found a total 53000 separations, and a total of 1469335 inpatient days. The mean duration of inpatient stay was 27 days. **The average cost per admission, thus, was $32400**.

Considering the specific individual conditions for 2022-23 nationally for admitted episodes of care:

	Separations	Total bed-days	Admission duration
Schizophrenia	22410	820000	37 days
Bipolar disorder	13200	251000	19 days
Severe depression [psychosis]	230	5650	25 days

Audit data from NSW show that, in the supported accommodation of the HASI-CLS model, **contact with community mental health services** decreased by 10% in the first year in HASI-CLS and was 63.7% less if they remained in the programs for more than one year. **Hospital admissions due to mental health** decreased by 74% following program entry, and the average length of stay decreased by 74.8% over two years. **This improvement was sustained after consumers exited the programs**.

To estimate the expected effects if all unmet need in supported housing was dealt with, we have used the HPA analysis commissioned by the Commonwealth Government. That analysis estimated that 68.6% of Australian adults with a severe chronic mental health condition were not receiving support.

Assuming that adults with complex severe mental health conditions were over-represented in hospital admission statistics, then the 68.6% would equate to 1008000 bed days, representing **$1 210 000 000 annually**.

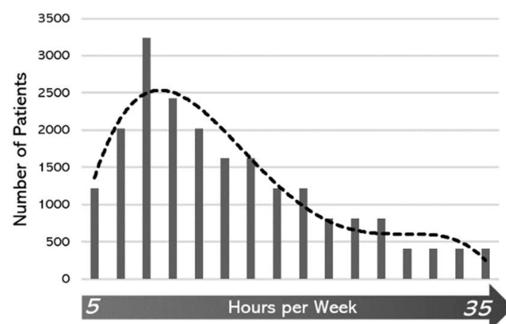
CLS- and Haven-type support have been found to reduce public hospital separations by 74%, and duration of the inpatient stays by 75%. Based on the HPA report estimates, 36360 separations would thus represent care for those not receiving community support. If all Australians who needed it were provided with adequate supported accommodation it would predict a reduction in the need for inpatient admissions to 9460 annually. The total need for inpatient admission, then, would be 16640+9460 = **26100 inpatient hospital admissions annually**. In view of the evidence of reduced inpatient duration of stay [estimated from the CLS audit] the expected reduction for each episode of admission [74% from the CLS audit] would predict a fall in total bed days required for all severe mental health conditions to 262080 [currently met need] + 461335 [current unmet need after adequate supported housing], **a reduction of 51% in the need for inpatient mental health beds**.

EFFECT OF SUPPORTED CARE ON COMMUNITY MENTAL HEALTH SERVICE NEED

Economic evaluation of the NSW CLS-HASI program revealed that supported community housing programs were able meet the following support requirements:

- 31.8% of people needing support required low level support – 5 hours or less per week.
- 66.6% of people needed medium level support – 5 hours per day to 5 hours per week
- 1.6% needed more than 5 hours per day.

Based on these audit results, we have scaled up the estimates of community psychosocial care that can be provided by assuming that for the persons requiring low level support that mean is 3 hours per week. For those requiring medium level support, a skewed distribution would be most likely:



Using these estimates based on providing supported community care to every one of the 31000 persons currently unable to access such care, as many as 19067000 hours of psychosocial support could be delivered through housing programs alone, **obviating $1 525 385 000 in psychosocial supports funded through other budgets**.

CONCLUSIONS

It is estimated that approximately 2% of all adult Australians are affected by a severe chronic mental health condition. These people live not only with the disability of their mental ill health, but commonly with physical health conditions and substance use issues. They have a greatly shortened life expectancy compared to other Australian adults – a situation that has not changed for decades. Mental illness affects all aspects of their lives, including their relationships, education, employment, and housing. Managing their condition often has a severe effect other family members and carers.

Numerous public inquiries – including a Royal Commission – have identified enormous gaps in the services provided to Australians affected by chronic severe mental health conditions. The problems identified include:

- Demand is unable to be met, leaving the system overwhelmed.
- Many of the people who most need community-based care and support cannot access it.
- Lack of access to care is leading to worsening both of mental and physical health.
- The services that are available are under-resourced, siloed, and poorly structured in terms of providing adequate care to people with multiple complex problems.
- First Nations' Australians, in particular, are suffering from a culturally-unsafe system and many are involved in the justice system with high levels of incarceration, exacerbating their already-severe problems.
- Services are particularly difficult to access outside of urban areas of Australia.

We have identified the **three key issues leading to unmet need** as:

A lack of supported accommodation. Secure and supported housing is fundamental to recovery from acute relapses in conditions such as schizophrenia and other severe psychotic conditions. There is strong evidence that such appropriate accommodation reduces the need for psychosocial services, reduces the need for hospital-based care, and improves overall health thus reducing the demand for healthcare for physical conditions. Economic analysis has shown that the provision of supported accommodation for adults with chronic severe mental health conditions is cost-effective.

A lack of inpatient mental health hospital beds and associated services. The number of dedicated mental health beds in Australian hospitals is way below the OECD average, leading to an estimate of almost 11000 such beds nationally. However, our analysis suggests that if all Australians who need it were provided with appropriate supported mental health accommodation, the resulting reduction in the need for hospital admission would equal the bed number shortfall, obviating the need for additional beds.

A lack of skilled workforce to provide care. Estimates suggest that the total shortfall in mental health workforce is approximately 8200 FTE and of drug and alcohol workforce of approximately 840 FTE annually, representing over 9000 FTE in total. However, if supported housing was available for every Australian with a severe chronic mental health condition who needed it, the requirement for community mental health services is estimated to reduce by approximately 74% for patients settled in long term supported accommodation. This would, again, reduce the need for additional workforce over and above those employed in – and budgeted for – in supported accommodation.

Overall, then, it is likely that the provision of supported accommodation for Australians with chronic severe mental health conditions is likely to greatly reduce the burden both on community services and our public hospitals and emergency departments. An effort to overcome the siloing of mental health services, physical health care, and alcohol and drug services will greatly improve the efficiency of the overall system in dealing with residual care needs. These steps will improve the capacity for those affected to participate fully in our community, and minimize the burden of care for family members and allow them to more fully contribute to the economy.

For all of these reasons we can no longer walk by…

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