Mental Health Australia

National Disability Strategy

Submission to Stage 2 consultation

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Mentally healthy people,
mentally healthy communities

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Mental Health Australia is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector and committed to achieving better mental health for all Australians. It was established in 1997 as the first independent peak body in Australia to represent the full spectrum of mental health stakeholders and issues. Mental Health Australia members include national organisations representing consumers, carers, special needs groups, clinical service providers, professional bodies, public and private mental health service providers, researchers and state/territory community mental health peak bodies.

Mental Health Australia aims to promote mentally healthy communities, educate Australians on mental health issues, influence mental health reform so that government policies address all contemporary mental health issues, conduct research on mental health issues, and carry out regular consultation to represent the best interests of our members, partners and the community. These endeavours in education and policy reform are matched by our commitment to researching more innovative approaches to the provision of mental health care. In addition, Mental Health Australia continues to focus on the human rights of people with a mental illness.

One in five Australians are affected by mental illness annually. We cannot afford to be complacent in our efforts to achieve changes to our mental health care system when we consider the impact of mental ill-health on our community.

Introduction

Mental health is a continuum, which includes wellbeing and mental illness and psychosocial disability. Psychosocial disability is a term used by mental health service providers, consumers and carers to describe the disability experience of impairments and participation restrictions related to mental illness. These impairments and participation restrictions include loss of or reduced abilities to function, think clearly, experience full physical health and manage the social and emotional aspects of life. [1] Not all people who experience mental illness have a psychosocial disability; while approximately 20% of Australians will experience mental illness in any given year, 4.5% of Australians live with psychosocial disability.

People with psychosocial disability make up nearly a quarter of all people with disability.[2] Additionally, people with disability on average have poorer mental health outcomes than people without disability. One measure of the mental health of a population is 'psychological distress.' In Australia, 32% of adults with disability experience high or very high psychological distress, compared with 8% of people without disability.[3] People with disability experience many risk factors which can lead to mental illness, including discrimination, social isolation, lack of employment opportunities, and financial difficulty.[4]

In the mental health sector, the term "consumer" is used to recognise people who identify as having a lived or living experience of mental health issues, including psychosocial disability. The term "mental health carers" is used to refer to informal carers, often family members, who provide support for a person experiencing mental illness.[5] The lived experience or peer workforce is a growing component of the mental health workforce, where mental health consumers and carers apply their lived experience of dealing with mental health challenges or supporting someone through mental health challenges, in an identified role to support others experiencing mental health issues. The lived experience workforce is an important aspect of support for people living with psychosocial disability.

Recovery-oriented approaches are accepted best practice in mental health services and psychosocial disability support. There is no single definition or description of recovery, but it can be understood to mean 'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues.'[6]

As often is the way, the revision of the National Disability Strategy (the revised Strategy) comes at a time where there are numerous other reviews, revisions, and new policy developments across the disability sector - and the health and ageing sectors more broadly. In the mental health sector specifically, the imminent release of the final report from the Productivity Commission's *Inquiry into Mental Health* is anticipated to deliver a vision for significant reform. With each national policy change and revision likely to have a substantial impact on the way services are delivered for people with disability, the Federal Government must be mindful of the possible unintended consequences of other policy changes. This is particularly the case where the landscape is still uncertain and likely to remain so for some time. Mental

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[1] National Mental Health Consumer & Carer Forum (2011). *Unravelling Psychosocial Disability, A Position Statement by the National Mental Health Consumer & Carer Forum on Psychosocial Disability Associated with Mental Health Conditions.* Canberra: NMHCCF.
[2] Australian Bureau of Statistics (2015). *Disability, Ageing and Carers, Australia: Summary of Findings, 2015*. Canberra: ABS. Retrieved 10 September 2020 from **https://www.abs.gov.au/ausstats/abs@.nsf/Previousproducts/4430.0Main%20Features902015?opendocument&tabname=Summary&prodno=4430.0&issue=2015&num=&view**=.
[3] Australian Institute of Health and Welfare (2019) *People with disability in Australia* [accessed at **https://www.aihw.gov.au/reports/disability/people-with-disability-in-australia/health/health-status/mental-health**]
[4] Beyond Blue (2019) *Looking after your mental health while living with a disability* [accessed at **https://www.beyondblue.org.au/personal-best/pillar/in-focus/looking-after-your-mental-health-while-living-with-a-disability**]
[5] Mental Health Carers Australia (2019). *What is a mental health carer?* Accessed 3 November 2020 at **https://www.mentalhealthcarersaustralia.org.au/mental-health-carers/**
[6] Australian Health Ministers' Advisory Council (2013) *A National Framework for Recovery-Oriented Mental Health Services. Retrieved 3 November 2020 from:* **https://www1.health.gov.au/internet/main/publishing.nsf/Content/67D17065514CF8E8CA257C1D00017A90/$File/recovgde.pdf**

Health Australia offers the assistance of its members to the Federal Government as it navigates these complexities and as critical cross-portfolio and cross-jurisdictional matters are resolved.

When Australia ratified the United Nations Convention on the Rights of Persons with Disabilities (CRPD) in 2008, the Federal Government undertook to consider the protection and promotion of the human rights of persons with disabilities in all policies and programmes. The revised National Disability Strategy is an opportunity to truly ground national disability policy in Australia in human rights.

Summary of recommendations

This submission includes a range of recommendations to guide the drafting and development of the revised Strategy:

Recommendation 1: All governments should provide funding for structures that strengthen and embed the voices of people with lived experience in national policy design, implementation, monitoring and evaluation. This includes funding for consumer and carer leadership and representation structures.

Recommendation 2: The Federal Government should develop and implement a supported decision-making framework for mental health and psychosocial disability support services, in line with its obligations under the United Nations Convention on the Rights of Persons with Disabilities.

Recommendation 3: In the final revised Strategy, clearly articulate the application parameters of the guiding principles.

Recommendation 4: The Federal Government should resource a nationally coordinated and evidence-based prevention, early intervention and anti-discrimination campaign, including community-wide education and tailored strategies for mental health services, emergency services, workplaces, schools, early childhood services and other key settings for health promotion, prevention and early intervention.

Recommendation 5: All governments should require workers in all services that support people with disability to undergo a minimum level of mental health training. Training could be incorporated into accreditation processes or delivered on-the-job.

Recommendation 6: Governments should identify the potential impacts of policy changes on mental health outcomes across portfolios and jurisdictional boundaries. Treasury and/or Finance Departments of all governments should also reconfigure their Budget rules in order to allow Ministers to account for savings in one portfolio as a result of investment in another portfolio, and to better recognise longer-term down-stream savings that stem from government investments in areas such as psychosocial services, employment supports and securing stable housing.

Recommendation 7: Federal and jurisdictional governments jointly provide an annual “report card” to the community. People with disability (a mix of both NDIS participants and non-participants) co-design the indicators which are reported upon, and remain involved through formal leadership positions in the governance structure.

Recommendation 8: The revised Strategy must include a whole-of-Strategy Implementation Plan, in addition to proposed TAPs that must include consumers and carers as decision-makers and identify who will be delivering each aspect of the action plan to ensure accountability for delivery.

Recommendation 9: Governments should develop a national plan to support the development of the workforce necessary to support people with disability outside of the NDIS. This plan should sit within the Strategy, and acknowledge the unique skills required for the psychosocial disability workforce.

Recommendation 10: Governments should provide funding and support to develop a trained professional lived experience workforce, as well as incentives to integrate peer workers into all mental health services, multi-disciplinary teams and accident, emergency and other first responder services.

Recommendation 11: All sectors including government, non-government, industry and private sector must work to reduce the barriers to employment that will increase economic productivity and social participation.

Outcome areas

In addition to the proposed outcome areas, it is critical that the issue of safety from violence is elevated to either its own outcome area, or a cross-cutting principle. The Royal Commission into the Violence, Abuse, Neglect and Exploitation of People with Disability has released its interim report,[7] which details widespread abuse across a range of settings for all people with disability.

People with psychosocial disability, and people with disability with co-morbid mental illness, are significantly more likely to experience violence than people without disability.[8] Amongst adults with disability, the cohorts most likely to have experienced violence after the age of 15 have:

- psychological disability (65% or 587,000 people)
- intellectual disability (62% or 295,000 people)
- head injury, stroke or brain damage (60% or 110,000 people).[9]

These cohorts experience violence at rates that are almost double the rate of those without disability (36%).[10] Consequently, it would be remiss to not recognise the very serious problem of violence, abuse, neglect and exploitation of people with disability in the revised Strategy.

Mental Health Australia notes the Department of Social Services has released the consultation paper on the outcomes areas of the Strategy, and will provide more detailed comment in response to that consultation.

National Disability Strategy Engagement Plan

The United Nations' *Convention on the Rights of Persons with Disabilities* states that every person has the right to make decisions about things that affect them, and requires governments to take appropriate measures to provide the necessary support that people may require exercising this right. Consumers and carers are the experts in what services work for them, and meaningful involvement of people with lived experience should be at the heart of service design, delivery and evaluation. Consumers and carers must be involved in decisions that affect them from the services available locally to the development of national policy.

In principle, an Engagement Plan which "articulates governments' commitment to ensure that people with disability can actively participate in shaping future disability policies, programs and services" could provide this guidance. However, true empowerment of people with disability to exercise their decision-making rights will require more than an advisory body to government. Rather, both federal and jurisdictional governments must genuinely create structures that embed people with disability into decision-making positions, not solely in advisory positions to abled decision-makers.

Recommendation 1: All governments should provide funding for structures that strengthen and embed the voices of people with lived experience in national policy design, implementation, monitoring and evaluation. This includes funding for consumer and carer leadership and representation structures.

Additionally, to truly engage with consumers and carers representing the spectrum of people with disability, the Federal Government must develop a clear, nationally applicable framework for supported decision-making in the disability sector. Supported decision-making is an important part of ensuring that consumers

[7] Attorney-General's Department (2020). *Royal Commission into the Violence, Abuse, Neglect and Exploitation of People with Disability*. Retrieved 30 October 2020 from **https://disability.royalcommission.gov.au/system/files/2020-10/Interim%20Report.pdf**.
[8] Australian Institute of Health and Welfare (2020). *People with disability in Australia - Violence against people with disability*. Retrieved 28 October 2020 from **https://www.aihw.gov.au/reports/disability/people-with-disability-in-australia/contents/justice-and-safety/violence-against-people-with-disability**.
[9] Australian Bureau of Statistics (2017). *Personal safety, Australia*. Retrieved 28 October 2020 from **https://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/latest-release**.
[10] Australian Bureau of Statistics (2017). *Personal safety, Australia*. Retrieved 28 October 2020 from **https://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/latest-release**.

and carers have the knowledge that they need to exercise choice and control. Supported decision making can help to address the specific barriers that people with psychosocial disability face in exercising choice and control, such as difficulties with cognition, communication and self-advocating, or estrangement from family and other support networks.

Recommendation 2: The Federal Government should develop and implement a supported decision-making framework for mental health and psychosocial disability support services, in line with its obligations under the United Nations Convention on the Rights of Persons with Disabilities.

Proposed guiding principles

While the proposed guiding principles expressly acknowledge they are built from the principles set out in Article 3 of the *Convention on the Rights of Persons with Disabilities,* it will be critical that the final version of the revised Strategy sets out these obligations alongside the proposed principles.

Mental Health Australia supports the proposed guiding principles, however it is unclear whether the revised Strategy intends for these principles to apply to *all* government policy and programs, or just disability specific policy and programs. We strongly recommend that these principles apply to *all* government policy and programs, so that pockets of disability excellence are not siloed, but rather are the norm across government systems and responsibilities. Additionally, it is unclear whether these principles are intended to retroactively apply to existing policy and programs, or only apply to newly developed initiatives. Acknowledging the difficultly in retroactively applying principles, not doing so also introduces the risk that these principles are not embedded until major policies and programs are reviewed, some of which happens only once a decade.

Recommendation 3: In the final revised Strategy, clearly articulate the application parameters of the guiding principles.

Community attitudes

Mental Health Australia welcomes a focus on community attitudes in the revised Strategy. Until the issue of community stigma about mental illness is addressed, significant challenges for people with disability and mental illness, and people with psychosocial disability, will remain.

Despite progress over the last decade, there is still a great deal of stigma associated with mental illness, and even more so with psychosocial disability. There is generally a low level of understanding and many misconceptions about mental illness, including attitudes of fear, which contribute to stigma and self-stigma.

The many individual and systemic challenges faced by people with mental illness can be directly attributed to lack of awareness, stigma, and discrimination.[11] Community attitudes towards people with disability, and particularly people with mental illness, are reflected in all types of interactions, from negative comments from strangers through to discrimination in employment, housing and social engagement. Changing community attitudes is a massive (but necessary) undertaking, and must recognise that systems reflect the values of a community. In order to remove stigma and fight ableism in our communities, there must also be a movement to remove stigma and fight ableism in every system which supports people with disabilities.

Stigma can have a range of poor outcomes for both the person with mental illness or psychosocial disability, as well as others in their life. Common harms caused by stigma include:[12]

[11] National Mental Health Commission. (2012). *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention.* Canberra: NMHC.
[12] SANE Australia (2014). *The SANE Guide to Reducing Stigma*. Retrieved on 10 September 2020 from **https://www.sane.org/images/PDFs/SANE-Guide-to-Reducing-Stigma.pdf**.

- discouraging help-seeking behaviours
- making recovery harder – where people with psychosocial disability are not engaged or become disengaged from the workforce due to stigma, this makes their recovery journey more difficult
- increasing discrimination – stigma can amount to discrimination in social, employment, and health care contexts
- increasing isolation – experiencing stigma can cause people with psychosocial disability to withdraw from social aspects of work (and life), which can lead to poorer wellbeing outcomes.

Recommendation 4: The Federal Government should resource a nationally coordinated and evidence-based prevention, early intervention and anti-discrimination campaign, including community-wide education and tailored strategies for mental health services, emergency services, workplaces, schools, early childhood services and other key settings for health promotion, prevention and early intervention.

Health professionals and disability support workforce can also exhibit such stigma towards people with psychosocial disability, or mental illness. When this stigma is received from a health professional providing mental health services the impact is likely to impede recovery and result in poor outcomes for the individual.[13] A literature review of attitudes of health professionals towards people with psychosocial disability and people with mental illness found "negative and stigmatising remarks were commonly reported by consumers who felt disrespected and treated as less competent as a result of having a mental illness."[14]

Recommendation 5: All governments should require workers in all services that support people with disability to undergo a minimum level of mental health training. Training could be incorporated into accreditation processes or delivered on-the-job.

Strengthening accountability

Federal, jurisdictional and local governments

Different aspects of support for people with disability are siloed across different levels of government, and within government across separate portfolios. While inherently interconnected, this means that investments in one area (such as housing) that would support outcomes in other areas (such as economic and social participation) are disconnected. Greater integration of these accountability and funding structures is fundamental in progressing towards a person-centred support system. It is also crucial in providing visibility of the real costs and savings from investments. .

An immediate step on this path is for governments to examine how the potential economic impacts of policy changes which may affect disability outcomes are accounted for across portfolios. This may mean reconfiguring current Federal Budget rules in order to better recognise the longer-term and cross-portfolio impacts of investments, such as by allowing ministers to account for 'down stream savings' as a result of investment in housing or employment.

[13] Mental Health Australia (formerly Mental Health Council of Australia) (2013). *Consumer and carer experiences of stigma from mental health and other health professionals.* Retrieved 28 October from **https://mhaustralia.org/sites/default/files/imported/component/rsfiles/publications/Consumer_and_Carer_Experiences_of_Stigma_from_Mental_Health_and_Other_Health_Professionals.pdf**.

[14] Mental Health Australia (formerly Mental Health Council of Australia) (2013). *Consumer and carer experiences of stigma from mental health and other health professionals.* Retrieved 28 October from **https://mhaustralia.org/sites/default/files/imported/component/rsfiles/publications/Consumer_and_Carer_Experiences_of_Stigma_from_Mental_Health_and_Other_Health_Professionals.pdf**.

Recommendation 6: Governments should identify the potential impacts of policy changes on mental health outcomes across portfolios and jurisdictional boundaries. Treasury and/or Finance Departments of all governments should also reconfigure their Budget rules in order to allow Ministers to account for savings in one portfolio as a result of investment in another portfolio, and to better recognise longer-term down-stream savings that stem from government investments in areas such as psychosocial services, employment supports and securing stable housing.

To enable this, federal and jurisdictional governments need to agree on their respective roles and how they will work together. For psychosocial disability, acute clinical mental health services are necessary, but are only one part of a person's support needs. Other services can help reduce the demand for expensive crisis services.

Poor mental health outcomes (for people with psychosocial disability, people with disability, and the general community) also present major financial risks for states and territories, which are in addition to running hospitals, fund prison systems, homelessness services and other crisis interventions. These risks can also be mitigated by improving the way federally-funded systems, such as primary care and employment services, respond to the needs of people with mental illness.

Collecting data, measuring outcomes, reporting requirements, and evaluation

A core principle which carries from the original Strategy (and is embedded in the NDIS) is that disability is an issue that concerns all Australians and therefore cuts across many social systems and community structures. As a COAG-endorsed strategy, the current Strategy has carried considerable moral weight, but its implementation is mostly carried out indirectly, through initiatives such as the NDIS and various government policies and programs.

The efficacy of the revised Strategy would be greatly enhanced if relevant councils/sub-bodies of the newly formed National Cabinet were explicitly responsible for monitoring and regularly publicly reporting on the performance of the relevant mainstream service systems in addressing the needs of all people with disability, whether they are receiving individually funded packages, supports outside of the NDIS, or neither. The monitoring process could be publicly reported through a "report card" on the state of disability in Australia for each state/territory or PHN region.

The report card must include meaningful indicators to people with disability, which are identified and developed through genuine co-design processes with consumers and their families and carers. These indicators should cover the full spectrum of quality, quantity and efficiency from the consumer and provider perspectives. It is critical to public trust that publicly reported data is real-time (no older than 12 months at time of reporting).

This monitoring and reporting should cover, at a national level, service systems established through Primary Health Networks (PHNs) and services provided through Medicare. State and territory-funded mental health services (clinical and non-clinical; acute and non-acute; residential and community-based) must also be within scope, given the significant amount of disability support care delivered by and through jurisdictions.

A similar reporting mechanism already exists in the mental health space – the National Mental Health Commission's second-yearly Progress Reports[15] which monitor mental health and suicide prevention reform as is set out in the *Fifth National Mental Health and Suicide Prevention Plan.* The 2018 Progress Report is structured by 24 performance indicators, and sets out what the indicator measures, why it is

[15] National Mental Health Commission (2018). *Monitoring mental health and suicide prevention reform: Fifth National Mental Health and Suicide Prevention Plan.* Sydney: NMHC. Retrieved 28 October 2020 from **https://www.mentalhealthcommission.gov.au/getmedia/475901fc-97d9-4419-9069-1f7bd7c25419/Fifth-National-Mental-Health-and-Suicide-Prevention-Plan-2018-Progress-r.pdf**.

important, what the caveats are, and a summary of data with digestible information like charts and other figures. This reporting is in addition to the annual National Reports produced by the National Mental Health Commission.

Recommendation 7: Federal and jurisdictional governments jointly provide an annual "report card" to the community. People with disability (a mix of both NDIS participants and non-participants) co-design the indicators which are reported upon, and remain involved through formal leadership positions in the governance structure.

Targeted Action Plans

While Targeted Action Plans (TAPs) have the potential to drive rapid, necessary change in the disability sector, they are not without their own risks and complications. As it is worded in the Position Paper, it implies that TAPs are in place of a broader implementation plan. Mental Health Australia believes that an overarching Implementation Plan must sit above the proposed TAPs, to ensure co-ordination and synchronicity where relevant. Without a whole-of-Strategy Implementation Plan, there is risk of losing focus on the progress of holistic, system-wide and cross-system reforms.

There is significant concern within the disability sector about the lack of progress against the outgoing Strategy, despite the development of two Implementation Plans. While the TAPs have potential to be the rallying call to greater implementation of the Strategy, they must be adequately funded and resourced with public accountability.

Mental Health Australia is also concerned about how issues will be identified and prioritised as the focus of TAPs. Without the overarching direction provided in a whole-of-Strategy Implementation Plan, there is risk of both further deepening siloes within and beyond the disability sector, as well as risk that the TAPs will address the "easy fixes" rather than tackling the broader, systemic challenges. People with psychosocial disability have largely been an afterthought in disability policy and programs (for example, late inclusion in the NDIS), and we are concerned that TAPs could reinforce the hierarchy of condition-specific attention which the disability sector has moved away from over the last decade.

Recommendation 8: The revised Strategy must include a whole-of-Strategy Implementation Plan, in addition to proposed TAPs that must include consumers and carers as decision-makers and identify who will be delivering each aspect of the action plan to ensure accountability for delivery.

Workforce development

The Position Paper makes fleeting reference to workforce development, noting that federal and jurisdictional governments are currently developing "a National Disability Insurance Scheme (NDIS) National Workforce Plan, which will outline a national approach to disability workforce development." While the NDIS is now rolled out and growing in participant numbers, it is only modelled to support around 500,000 Australians with disability, which is barely more than 10% of the approximate 4.3 million Australians with disability.[16] Therefore, Mental Health Australia believes that the development of an NDIS workforce plan should not preclude the development of a broader disability workforce plan, which would sensibly sit within the revised Strategy.

There needs to be an innovative, collaborative approach to develop and sustain the workforce needed to support Australians living with psychosocial disability. Moving forward, a recovery-oriented, trauma informed, culturally responsive, and diverse workforce is needed to support people wherever they live. The

[16] National Disability Insurance Scheme (2020). *What is the NDIS*? Retrieved 28 October 2020 from **https://www.ndis.gov.au/understanding/what-ndis**.

future workforce will also be shaped by greater incorporation of technology, with opportunities to provide more integrated care through use of digital devices and data systems.[17] This brings both challenges and opportunities, as can already be seen by changes in response to the COVID-19 pandemic.

Psychosocial disability differs to other forms of disability in key ways, which means it requires a unique approach in disability policy and practices. The uniqueness of psychosocial disability is that, rather than physical barriers, consumers primarily experience cognitive, social and motivational barriers to activities of daily living. These barriers can be addressed through a coaching approach that is personalised to the individual, builds on their strengths and maximises their potential to manage everyday life and participate in the community. This emphasis on engagement and capacity building means it is crucial that workers have psychosocial disability-specific skills, knowledge and experience and that they bring a high degree of sensitivity and empathy to the task of working with people experiencing psychosocial disability.

Within the NDIS, psychosocial support providers have the highest proportion of clients with complex behaviour needs compared to other service providers (34.4% compared to 16.7%).[18] Further, participants with psychosocial disability and acquired brain injury are the only cohorts to identify goals relating to “Social and Community Activities” more frequently than goals relating to “Daily Life”. These trends emphasise the unique needs of the psychosocial disability cohort, and the required skills of the psychosocial workforce in capability building and recovery-oriented care.

Recommendation 9: Governments should develop a national plan to support the development of the workforce necessary to support people with disability outside of the NDIS. This plan should sit within the Strategy, and acknowledge the unique skills required for the psychosocial disability workforce.

Lived experience workforce

A commitment from the Federal Government through the revised Strategy to fund the expansion of a paid lived experience workforce in the disability sector, particularly for people with psychosocial disability or mental illness in addition to disability. This commitment would build the evidence base regarding the cost/benefit of providing lived experience workers to support people receiving care. It would also help to establish the return-on-investment to employers and governments, and to help establish the various structures and processes required to sustain this work.

Lived experience workforces represent an opportunity to expand the disability workforce at a time of increasing need, while also testing the potential to reduce JobSeeker and Disability Support Pension costs over the long term by providing training and employment opportunities in peer work for people with lived experience.

Recommendation 10: Governments should provide funding and support to develop a trained professional lived experience workforce, as well as incentives to integrate peer workers into all mental health services, multi-disciplinary teams and accident, emergency and other first responder services.

Supporting people with disability to work

For many people with mental illness (including people with psychosocial disability), their participation in work has been limited by policy settings, a lack of support resources, and a lack of information and awareness. Employment rates are poor for people with any disability, but are particularly poor for people with psychosocial disability.

Australia lags well behind other countries in truly addressing the employment of people with psychosocial disability. This is despite many expressed commitments to improving the rate of employment amongst

people experiencing mental illness. To meaningfully increase the employment of people with psychosocial disability, we have to do more than develop new policy statements.

Without deliberate strategies to directly address the barriers faced by people with psychosocial disability in seeking, finding and keeping employment, current challenges for people with psychosocial disability will continue.

Recommendation 11: All sectors including government, non-government, industry and private sector must work to reduce the barriers to employment that will increase economic productivity and social participation.

Conclusion

The revision of the National Disability Strategy provides a momentous opportunity to more fully enshrine the rights of people with disability, and improve the systems which support them. People with psychosocial disability represent nearly a quarter of people with disability in Australia, with many more people with disability living with co-morbid mental illness. The revised Strategy can be further strengthened to better meet the needs of people with psychosocial and other disabilities, by prioritising safety from violence, establishing structures to support lived experience leadership, addressing stigma, providing greater integration and accountability across and within governments, and supporting the development of the lived experience workforce. The success of the Strategy should be supported by an over-arching implementation plan as well as Targeted Action Plans, a disability workforce strategy (beyond the NDIS workforce), and release of an annual public “report card” to provide real-time public accountability of services. These actions would allow governments to seize this opportunity to shape a “COVID normal” world, to improve social, economic and health outcomes for people with disability, and move towards a truly inclusive society where everyone’s rights are respected, their needs are met, and the world is accessible.

Mental Health
Australia

Mentally healthy people,
mentally healthy communities

Mental Health Australia is the peak independent national representative body of the mental health sector in Australia.

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