National Mental Health Consumer & Carer Forum

A combined national voice for mental
health consumers and carers

Submission in response to the Productivity Commission Inquiry into
Mental Health

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Consumer & Carer Forum

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The National Mental Health Consumer and Carer Forum (NMHCCF) is pleased to provide a submission to the Productivity Commission inquiry into Mental Health.

The NMHCCF is a combined national voice for mental health consumers and carers. We listen, learn, influence and advocate in matters of mental health reform. The NMHCCF was established in 2002 by the Australian Health Ministers' Advisory Council. It is funded through contributions from each state and territory government and the Australian Government Department of Health. It is currently auspiced by Mental Health Australia.

NMHCCF members represent mental health consumers and carers on a large number of national bodies, such as government committees and advisory groups, professional bodies and other consultative forums and events. Members use their lived experience, understanding of the mental health system and communication skills to advocate and promote the issues and concerns of consumers and carers.

The NMHCCF acknowledges there are a vast range of issues the Productivity Commission will be addressing during this inquiry. Our submission focuses on embedding lived experience voices in all aspects of mental health and provides advice and recommendations on peer workforce and co-design.

Peer workforce and co-design are two areas we believe have genuine potential to be expanded on and produce outcomes that positively improve the lives of mental health consumers and carers.

We have also included other recommendations and opportunities for possible further exploration that have been identified by mental health consumers and carers that are beyond the peer workforce and co-design.

If you wish to discuss any of the information provided in this submission, please do not hesitate to contact the NMHCCF via the Secretariat – nmhccf@mhaustralia.org or 02 6285 3100.

Yours sincerely

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Consumer Co-Chair   Deputy Carer Co-Chair

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Peer Workforce

The mental health consumer and carer identified workforce comprises those consumers and carers who are employed specifically for their expertise developed from their lived experience of mental illness as a consumer or a carer.[1]

Peer workers are people who have lived experience of mental health issues themselves or have cared for someone with a mental health issues.

> "...a deep, holistic understanding based on mutual experience where people are able to "be" with each other without the constraints of traditional (expert/patient) relationships...Peer Support can offer a culture of health and ability as opposed to a culture of "illness" and disability."[2]

The Fifth National Mental Health and Suicide Prevention Plan: Implementation Plan (Fifth Plan) acknowledges "...that peer workers play an important role in building recovery-oriented approaches to care, providing meaningful support to people and modelling positive outcomes from service experiences. However, the peer workforce is sporadically utilised and poorly supported."[3]

There are great opportunities to grow the peer workforce across the country. NMHCCF members have suggested recommendations and provided examples of best practice, which could be expanded to meet this aim. We call for a national target for peer workers in mental health related support services. This target aims for 50 per cent of services employing peer workers in four years and 100 per cent in ten years.[4]

Recommendation: Implement a peer workforce within and across mental health services

Suggested recommendation the Productivity Commission could make in their report and examples of best practice relating to the peer workforce can be found in table 1.

Co-Design

Mental health consumers and carers are directly impacted by the quality and effectiveness of mental health care and thus may be considered the key stakeholders in mental health policy reform. Consumer and carer participation in determining mental health practices and priorities ensures a sound basis for successful processes, programs and services to maintain and improve the mental health of all Australians.[5]

Mental health consumers and carers have the right to participate in, actively contribute to, and influence the development of government policies and programs that affect their lives.[6] Genuine engagement results in greater consumer and carer empowerment and ownership of mental health programs.[7,8]

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[1] NMHCCF. (2011). *Peer workforce advocacy brief*
[2] Mead, S., Hilton, D., & Curtis, L. (2001). *Peer Support: A theoretical perspective.* Psychiatric Rehabilitation Journal, 25(4), p397-411
[3] Department of Health. (2017). *The Fifth National Mental Health and Suicide Prevention* Plan, p45
[4] National Mental Health Commission. (2013). *A Contributing Life, the 2013 National Report Card on Mental Health and Suicide Prevention. P57.*
[5] Adapted from National Consumer and Carer Forum (2004). *Consumer and Carer Participation Policy: a framework for the mental health sector*
[6] Adapted from National Consumer and Carer Forum (2004). *Consumer and Carer Participation Policy: a framework for the mental health sector*
[7] Slay, J & Stephens, L., (2013). *Co-production in mental health: A literature review*
[8] World Health Organization (2010). *User empowerment in mental health – a statement by the WHO Regional Office for Europe*

Co-design and co-production needs to be given specific consideration in mental health as there is likely to be considerable power differential between consumer and non-consumer partners.[9]

Consumer and carer co-design is identified as a key commitment in the Fifth Plan, however insignificant funding has been allocated to achieve it. Genuine commitment to co-production and/or co-design is properly resourced, embedded from the outset, effects real change; and can successfully measure meaningful outcomes for consumers and carers.[10]

Recommendation: Have sufficient resources and structures embedded in services to facilitate co-design and co-production.

Reform systems and processes must acknowledge and respect the contributions, experience, unique expertise, skills and knowledge of consumers and carers.[11] The investment into a national consumer and carer peak body will assist in addressing and progressing the needs, issues and solutions identified by mental health consumers and carers. This body would be co-designed and able to contribute to mental health reforms and transformations.

Recommendation: Invest in a national consumer and carer peak body that is co-designed and sustainable.

Suggested recommendations the Productivity Commission could make in their report relating to co-design and an example of best practice can be found in table 2.

Other Matters

NMHCCF members have also identified opportunities for expansion and improvement in areas other than co-design and peer workforce, including:

- Carers payment and carers allowance – there is concern over the current means tests for the carers payment and carers allowance. It is recommended the test be altered to include criteria relevant to mental health carers.

- Housing and homelessness – there is a lack of affordable, safe and appropriate housing for people with lived experience of mental ill health.[12] The NMHCCF have provided some examples of best practice that can be built on and expanded nationally.

- Justice response – it is recommended the Productivity Commission review the success of co-located, integrated, shared and collaborative services in emergency response services.

These matters can be found in table 3.

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[9] Roper, C., Grey, F., & Cadogan. (2018). *Co-production - Putting principles into practice in mental health contexts* (pp. 8)
[10] NMHCCF. (2017). Co-Design and Co-Production Advocacy Brief
[11] NMHCCF. (2017). Co-Design and Co-Production Advocacy Brief
[12] AHURI. (2018). *Housing, homelessness and mental health: towards systems change*, p1

Recommendations and examples of best practice – peer workforce and co-design

Table 1 and 2 below provide recommendations and examples of best practice from the NMHCCF to the Productivity Commission on peer workforce and co-design. They include links to reports, programs and research that support the recommendations. If at any time during the inquiry the Productivity Commission would like to explore any of these further, the NMHCCF will be pleased to assist.

Table 1			
Peer workforce		**Rationale / Evidence**	**Further information**
Recommendation	Implement a peer workforce within and across mental health services	The 2018 report, *Investing to Save*[13]*,* suggests that the possible flow on effect of having a comprehensive peer workforce within and across mental health services could increase employment rates, lower disability support payments and could improve the mental health of both the peer worker and the individual receiving the support. A substantial peer workforce may relieve pressure in currently over crowded health services where mental health is unjustly represented. Peer workers have been identified as being able to contribute to better health outcomes, and are employed in significant numbers in countries similar to Australia. There is evidence to suggest that peer workers offer a number of benefits, and can reduce the rate of hospital admissions for the service users with whom they work.[14]	https://mhaustralia.org/sites/default/files/docs/investing_to_save_may_2018_-_kpmg_mental_health_australia.pdf Recommendation 1.3 page 35 http://www.mhcsa.org.au/wp-content/uploads/2018/12/HWA-Mental-health-Peer-Workforce-Study.pdf
Best Practice	Totally Peer Run Service	In an evaluation of a totally peer run service, Flourish, the analysis identified that the peer operated service delivered a social return on investment ratio of 3.27. That is, for every $1 invested, approximately $3.27 of social and economic value was created for stakeholders.	https://www.socialventures.com.au/sva-quarterly/the-value-of-a-peer-operated-service/

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[13] Mental Health Australia and KPMG (2018) *Investing to Save: the Economic Benefits for Australia of Investment in Mental Health Reform*, p35
[14] Health Workforce Australia (2014): Mental Health Peer Workforce Study

Table 1			
Peer workforce		**Rationale / Evidence**	**Further information**
Best Practice	Mental health crisis and respite services in communities that are staffed with a mix of peer worker and clinicians.	RI International run programs in the USA and NZ which have a focus on using peer workers as a core component of their staffing model. 100% of individuals entering RI Internationals community building program secured housing and on average nearly 75% that transition out of the program were stably housed when they exited the program.	https://riinternational.com/our-services/arizona/
Best Practice	Safe Haven Cafés (UK model) for suicide prevention/intervention and supporting people in mental distress.	Anyone with a mental health issue, whether diagnosed or not, can drop in for a cup of tea and a chat and can request more formal help if needed. A Safe Haven Café in the UK has helped reduce mental health hospital admissions by a third in seven months by providing an alternative solution for patients. The first trial of this model has now been started in Victoria. It is a program for consumers, developed by consumers and provides peer support to people as an alternative to attending an emergency department.	https://www.england.nhs.uk/mental-health/case-studies/aldershot/ http://www.health.vic.gov.au/healthvictoria/aug18/cafe.htm
Best Practice	Employing peer workers in hospital to reduce hospital readmission rates, improve recovery outcomes, improve consumers' experience of service, improve engagement with services and increase self-management.	A Federally Qualified Health Centre in Denver that used peer support had a return of interest of $2.28 for every $1 spent. A peer support program, Recovery Mentors, provided individualised support for schizophrenia, depression, bipolar disorder and over the course of 9 months, saw 0.89 vs. 1.53 hospitalisations and 10.08 vs. 19.08 days in hospital.	www.mentalhealthamerica.net/sites/default/files/Evidence%20for%20Peer%20Support%20May%202018.pdf

Table 1			
Peer workforce		**Rationale / Evidence**	**Further information**
Best Practice	Employing peer workers to fill gaps in services where it is difficult to recruit clinicians, particularly in rural and remote areas.	The Connections Program in NSW is a unique service staffed exclusively by peer workers to build connections between program participants and the broader community. The concept began as an innovative collaboration between Mission Australia and Far West Health to address a local need and reduce emergency room admissions and presentations after hours. Over six months, the program has been instrumental in reducing participant inpatient hospital days by 65%; and presentations to emergency departments by 80%.	https://www.missionaustralia.com.au/news-blog/news-media/sbs-draws-attention-to-connections-program-in-broken-hill

Table 2			
Co-design		**Rationale / Evidence**	**Further information**
Recommendation	Have sufficient resources and structures embedded in services to facilitate co-design and co-production.	Genuine co-design and co-production deliberately sets out to create a culture that values all expertise and knowledge, particularly the expertise and knowledge of the people that are most affected by the problem and solution. Co-production recognises and seeks to address power differentials within partnerships. Consumer and carer co-design is identified as a key commitment in the Fifth Plan and NDIS. This is a critical success factor for effective implementation.	https://recoverylibrary.unimelb.edu.au/__data/assets/pdf_file/0010/2659969/Coproduction_putting-principles-into-practice.pdf (page 5)
Recommendation	Invest in a national consumer and carer peak body that is co-designed and sustainable.	In recent years, there has been an increased call for consumer and carer engagement and participation across the mental health sector. Government reports, frameworks and mental health plans have shown intention to include consumers and carers at all levels of decision-making and policy development.	https://nmhccf.org.au/sites/default/files/docs/nmhccf_-_evaluation_-_final_evaluation_report_-_executive_summary_-_30_may_2017_0.pdf
Best Practice	Include consumers and carers in the design and implementation stages of services.	The Looking Forward Project in Western Australia. Twelve organisations agreed to work in partnership with the research team and 18 Aboriginal Elders to provide culturally accessible and responsive services to the Aboriginal people. Together they designed and implemented an engagement framework to create organisational change.	https://waamh.org.au/assets/documents/sector-development/lfp-final-research-report-2015---ecopy.pdf

Other recommendations and opportunities to be explored

This submission has been informed by the NMHCCF membership. During the process of gathering information, members put forward a range of recommendations and opportunities to be explored, including those identified below. We would also be pleased to discuss these further with the Productivity Commission.

Table 3		
Other Matters	**Recommendation / Opportunity**	**Evidence to support** (note, some of the recommendations come from lived experience)
Carers payment and allowance	The tests that are applied to carers for the carers payment and carers allowance are based on physical disability and not psychosocial disability. Carers have initial applications and reviews of applications denied because the tests give low scores of need. It is recommended the response to initial questions on the forms about physical/intellectual/mental health redirects the applicant to relevant and equitable questions.	Further information can be found in the submission number 72 to the Productivity Commission. https://www.pc.gov.au/__data/assets/pdf_file/0006/239235/sub072-mental-health.pdf https://nmhccf.org.au/sites/default/files/docs/submission_on_dss_draft_model_for_a_new_integrated_carer_support_service_system_0.pdf
Housing and homelessness of people with lived experience of mental illness	It is recommended the Productivity Commission review the Common Ground, Way2Home and Micah programs that provide supported accommodation to homeless people, including those with a mental illness. Support includes on-site manager, and assistance with education, training, job seeking and health. In a three year period (2010-2013), Micah saw inpatient hospital admissions decreased by 37% and visits to the Emergency Department decreased by 24%. Way2Home had 90% of individuals in sustained housing after 12 months, reduced use of alcohol and drugs, and 81% reporting positive life changes.	https://www.commongroundqld.org.au/housing/ https://espace.library.uq.edu.au/view/UQ:326267 https://micahprojects.org.au/assets/docs/Publications/IR_130_An-Economic-Evaluation-of-the-Homeless-to-Home-Healthcare-After-Hours-Service.pdf https://homeforgood.org.au/assets/docs/Publications/IR_127_A-Housing-First-Approach-to-Homelessness.pdf

| Justice response | It is recommended the Productivity Commission review co-located, integrated, shared and collaborative services.

A co-located, integrated, shared and collaborative service is a service that has embedded mental health workers into their workforce and work cooperatively to improve outcomes for mental health consumers and carers.

In Western Australia, the Mental Health Co-Response project embedded mental health clinicians at the Police Operations Centre, Perth Watch House and two mobile police teams.

The program was independently evaluated by Edith Cowan University after three years in operation. The evaluation reported a reduced need for consumers to be transported to hospital by police from 70 percent to 25 percent. | https://ww2.health.wa.gov.au/About-us/East-Metropolitan-Health-Service/About/EMHS-News/Mental-Health-Coresponse-project-a-finalist-in-multiple-excellence-awards |