Mental Health Commission of New South Wales

Submission to the Productivity Commission 2019 Draft Report on Mental Health

January 2020

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The Mental Health Commission of NSW

The Mental Health Commission of NSW (MHC) is an independent statutory agency responsible for monitoring, reviewing and improving the mental health system and advocating for reform. An effective mental health system as outlined in the *Mental Health Commission Act 2012* requires:

- *"a coordinated and integrated approach across all levels of government and the nongovernment sector, including in the areas of health, housing, employment, education and justice, and*
- *communication and collaboration between people who have a mental illness and their families and carers, providers of mental health services and the whole community.[1]"*

The MHC is focused on improving the mental health and wellbeing of the NSW community by undertaking strategic planning, systemic reviews and advocacy. In all of its work, the MHC is guided by the voice of people with a lived experience of mental health issues and/or caring, families and kinship groups.

Under the *Mental Health Commission Act 2012* the MHC is to take into account the particular views and needs of different sections of the community, including Aboriginal communities, culturally and linguistically diverse communities and regional and remote communities.

The vision of the Mental Health Commission is:

> *That the people of NSW have the best opportunity for good mental health and wellbeing and to live well in the community, on their own terms, having the services and supports they need to live a full life.*

The directions for improving the mental health and wellbeing of the people of NSW are set out in *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024*.

Living Well contains 141 actions to guide system reform to improve outcomes for people with lived experience of mental health issues and caring. The strategic plan is modelled on principles of recovery and person-centred care, emphasising choice and autonomy, and considers the personal and social dimensions of mental health issues alongside the impact on people's health. For this reason, *Living Well* outlined a whole-of-Government strategy that considered housing, education, employment assistance, family support and the judicial system among the spectrum of services that people may encounter and/or require when they experience mental health issues. By understanding the interactions of causal factors the experience of people with lived experience of mental health issues can be effectively improved.

Throughout 2019 the MHC undertook a mid-term review of *Living Well: A Strategic Plan for Mental Health in NSW 2014 – 2024*[2], the 10-year plan for mental health reform in NSW. As part of this review, the MHC consulted with over 1,300 stakeholders from around NSW to consider the effort that has been made against *Living Well* over the first five years and to identify priorities and opportunities for the remaining five years of the strategy. The community was clear in these consultations that they wanted supports and services in the community, to support them where they lived to keep them connected with family, kin and community, engaged in work, school and study. They wanted services and supports within a community based model that is navigable, affordable and provides early interventions to avoid hospital centred services or crisis emergency department presentations. Alongside this, was the need

for quality, accessible specialist care, which could be provided in step-up or step-down community facilities or hubs, not hospital facilities alone.

Aboriginal communities also emphasised they wanted culturally appropriate Aboriginal-led planned and designed services and supports, with a strong and sustainable Aboriginal mental health and wellbeing workforce, with Aboriginal organisations leading and providing these services for their community.

Equally, along with developing community based approaches that respond to psychological distress and mental health issues, is the priority for the growth, development and expansion of the peer workforce and peer led services.

These key community messages are relevant to the work of the Productivity Commission in finalising its work. They should encourage the Productivity Commission to strengthen responses that support participation in family, community, education, culture and employment. That take a person led, co-designed approach to developing the solutions away from institutions and establishing a comprehensive integrated community system of care and support, where hospitals are seen as a specialist part of a supportive community model working together to provide options for people to access support their mental health and recovery journey, and for carers, family and kin.

Navigation through the myriad of services and supports, accessibility and affordability were raised by communities, whether in metropolitan or rural areas. Proposals for a local commissioning approach by the Productivity Commission have great merit in addressing these issues. In any such structural reform, finalising a framework within which to co-commission and plan will need to be streamlined, not add a bureaucratic burden and have transparent governance and accountability mechanisms.

Overarching response to the Productivity Commission Draft Report on Mental Health

In April 2019 the MHC made a submission to the Productivity Commission's Inquiry informed by evidence, expertise and the voice of lived experience. The MHC advocated for a person and family focus. In our submission, it was proposed that:

> *Rather than focussing on the burden of disease for mental ill health, we recommended that **reducing the burden of obstacles be the foundation for a future strategy** aimed at improving the mental health of people and the mental health system.*

This approach requires system redesign which takes into consideration the social context and determinants of mental health, support social and economic inclusion. A more visible system that is easier to navigate will optimise outcomes for consumers and their carers.

The MHC welcomes the Productivity Commission's draft report released on 31 October 2019 and the recommendations included within. This second submission does not address the issues already mentioned to the inquiry, but rather presents a response to the draft report and its recommendations. The recommendations made in the report align well with what the MHC has heard during recent consultations conducted across NSW.

Economic productivity is intertwined with an individual's health, wellbeing, opportunities and the freedom to live a life of meaning, and it also has downstream benefits for families, communities, workplaces and the economy. It is heartening to see the Productivity

Commission take a whole-of-life approach to mental health that includes not only social and economic participation, but also education, employment, social services, housing and justice.

The MHC congratulates and thanks the Productivity Commission on their work developing the draft report. It is now up to the sector to work together to realise the opportunities this inquiry can bring to the wellbeing and mental health of our nation.

Priorities for the Mental Health Commission of NSW

While the MHC appreciates the recommendations and work done by the Productivity Commission to address the complex issue of recommending a way forward to improve the mental health and wellbeing 'system' to the benefit of people with lived experience, families and carers, and the community, the Commission is concerned that the recommendations and draft report do not include the particular views and needs of different sections of the community. The MHC places a priority in working with Aboriginal communities, culturally and linguistically diverse communities, people who identify as LGBTIQ+, those who are young and those from regional and remote communities, people who come into contact with the criminal justice system as well as people with co-existing issues, such as drug and alcohol use and physical disability. In partnership with people with lived experience of mental health issues and caring, we need to clearly set out the path forward to ensure outcomes are achieved, equitable and delivered where needs are greatest. Leadership by the Aboriginal and Torres Strait Islander community in planning that forward direction is critical.

Indigenous leadership is essential to promote the mental health and social and emotional wellbeing of Aboriginal people and communities. This goes beyond co-design and includes funding of Aboriginal organisations to autonomously design, develop and implement services that meet the needs of their people.

All proposed policy, system and practice changes across the full spectrum of mental health and suicide prevention should be considered in terms of their effect on Aboriginal people and their communities.

While the MHC appreciates the Productivity Commission's efforts in developing a whole of community approach to mental health reform, the MHC seeks to advocate for the particular views and needs of population groups that have unique needs and require appropriately designed responses. The MHC considers that these groups require more explicit consideration and may require adjustments in order to receive care that is appropriate, relevant and reduces exposure to trauma or harm. In turn, this more considered and appropriate response would be more effective in achieving outcomes for people, the community and the economy.

Governments and service providers need to be incentivised and supported to adopt models and approaches that address and account for the specific needs of different population and cultural groups. Recommendations around system reform should encourage service providers, planners, funders and sectors to develop new models through co-design with communities to ensure that revised approaches and frameworks are flexible to respond to the range of needs across communities, informed by evidence and evaluation, while incentivising innovation and community led solutions. The Productivity Commission needs to take a greater focus in addressing these issues in its final report, so that funding, workforce and cross-sector and person-inclusive approaches optimise personal and community wide outcomes.

Feedback on the Productivity Commission's Draft Recommendations

The MHC commends the Productivity Commission on encapsulating the whole-of-life approach that will be required to implement effective system change and improved outcomes for people with lived experience of mental health issues and caring, families and kinship groups. While the MHC broadly supports the recommendations made by the Productivity Commission and endorses the whole-of-life approach outlined, the MHC has particular comment on the following recommendations.

Draft Recommendation 7.1 — Planning Regional Hospital And Community Mental Health Services

This recommendation is a priority for the MHC. As part of the MHC's *Living Well* mid-term review consultation process, communities across NSW noted that the demand for mental health services in the community exceeds the available capacity.

While this recommendation supports the expansion of regional and community services and supports in line with community needs, the MHC notes that planning to support implementation of this recommendation must include the development of a regional, integrated model of care that is not solely reliant on hospital beds, and recognises and addresses the unique issues for building a sustainable rural mental health and wellbeing workforce.

A comprehensive model of care would include services that meet the specific needs of each region such as 24-hour community supports, and community services (step up and step down services). Primary care that comprises of general practice, consultant liaison services, mental health nurses, allied health, peer workers and Aboriginal mental health workers and Aboriginal medical services and hospital care should also be included the planning of a regional, integrated model of care. This also requires connected and sound information and data systems on service usage across the broad base of community services that can inform sound planning for the actual needs of the community, rather than only 'fit for purpose' planning sections of the mainstream mental health system. This for example includes housing, employment programs, education and training, social support, drug and alcohol services.

Regional planning and integrated care led collaboratively by Primary Health Networks, Local Health Districts (or equivalents), people with a lived experience and Community Managed Organisations (CMOs) are the key to successful pathways to support. Hospital beds are an important element of this service plan but cannot be planned in isolation from other services which can provide effective alternatives to inpatient care, and support ongoing recovery post admission. The MHC urges the Productivity Commission not to make recommendations about one element of the service system in isolation.

Draft Recommendation 8.1 — Improve Emergency Mental Health Service Experiences

Improving the experiences of people interacting with emergency mental health services is a priority for the Commission. Throughout the *Living Well* mid-term review consultation process emergency departments were consistently reported as becoming the first point of presentation due to the lack of availability of alternative services, particularly culturally appropriate, accessible services for Aboriginal people. At the same time, it is vital that people with a mental

health issue receive effective emergency care for their physical health needs. However, it is clear that this holistic service is not always available in current ED arrangements.

The *Living Well* review found that hospital episodes of care for mental health conditions has increased by 15 percent between 2013-14 and 2017-18[3], this is more than for episodes of care for physical health conditions. The Commission found that Aboriginal people in NSW used emergency departments for mental health related issues at three times the rate of non-Aboriginal people[4].

To reduce the reliance on emergency departments the MHC supports the recommendations' encouragement of improved and increasing available alternatives to hospital, including the development of 24/7 safe spaces, especially consumer (peer)-run safe spaces in settings outside of hospitals, that are culturally appropriate and accessible services, as well as the development of step-up step-down residential recovery-oriented services in the community.

The MHC suggests that this recommendation be amended to include an additional dot-point under 'In the short term (in the next 2 years)' which states:

- ***State and Territory Governments should provide more and improved access to peer run respite accommodation and provide continued investment in peer run services.***

The MHC notes that in order to reduce the reliance on emergency departments the development of a fully funded system of public community mental health assertive outreach teams including Aboriginal medical services, integrated peer support and comprehensive clinical crisis and ongoing case management services is necessary and essential.

Draft Recommendation 11.1 — The National Mental Health Workforce Strategy

The MHC endorses this recommendation and looks forward to the forthcoming update of the *National Mental Health Workforce Strategy*.

Throughout consultations conducted across NSW the MHC found that recruitment, retention and skills of the mental health workforce remain a major challenge for a flexible and responsive health and social service system. Workforce shortages were widely noted as a major issue, with rural and remote communities experiencing significant workforce shortages. Consultations demonstrated that the lack of access to specialist services increased with remoteness. There is value in thinking very differently about the current workforce models that apply to rural and remote areas.

Models that are flexible enough to build a local workforce within the local community require a realignment of professional education and training approaches that invest in people that already live and work in the location. This is a long term strategy that has some longer lasting benefits if these models are explored and supported. These models require an approach that is long term and can replicate successes. The NSW Aboriginal Mental Health Workforce Program[5] is one such model.

Furthermore, the MHC notes the importance of the development of a workforce that is flexible and planned locally to meet demand. Planning and workforce development should be linked to service and infrastructure planning, along with telehealth or online modalities. Adequate planning would enable adequate resourcing. Currently the concept of multidisciplinary teams has eroded as resourcing pressures have forced a shift to generic roles.

The MHC recognises the Productivity Commission's efforts in highlighting the necessity of a well-trained mental health workforce. Page 200 of the draft report outlines the substantial

challenges in developing a workforce that can address the needs of people experiencing mental distress. Increasing the number and capacity of non-clinical staff, such as peer workers, is a priority.

While the MHC recognises the importance of boosting the number of mental health nurses it believes that the development of the mental health workforce across all mental health systems should be reflective of the population characteristics. This includes the Aboriginal workforce and the peer workforce as a priority. If the peer workforce is developed and professionalised to align with new models that emphasise the importance of peer support alternatives alongside the mental health nurse workforce in multidisciplinary teams or in independent peer-led services, the needs of those requiring care can be better achieved. Development requires significant investment to build the numbers of peer workers to become a real and significant proportion of the mental health workforce. Despite community and industry perceptions, peer workers currently make up an insignificant proportion of the mental health workforce.

Draft Recommendation 11.4 — Strengthen The Peer Workforce

The MHC agrees with this recommendation and looks forward to the draft National Guideline on Peer Workforce Development in 2020. The guideline is consistent to Priority Area 8 of the *Fifth National Mental Health and Suicide Prevention Plan*[6] and is an effective anti-stigma intervention.

The MHC notes that on page 29 of the draft report, the Productivity Commission identifies barriers to the widespread use of peer workers. While the MHC agrees that one barrier to widespread use of peer workers is the acceptance of their role by clinicians, in our experience this can change rapidly once peer workers are in place and clinicians have the opportunity to work with them and see the direct benefits of their work. The MHC suggests that the Productivity Commission make specific mention of the need for investment in developing the peer workforce which is an additional barrier to the widespread integration of peer workers.

The MHC suggests the national guidelines should provide a guide to the variety of services that employ peer workers with recommendations on developing standardised service models, provide recommendations on supervision, support, core values and role functions including recommendations on leadership structures.

The MHC would support the development of implementation guidelines that consider local policy and state-based frameworks which aid the professional development of the peer workforce.

The MHC advocates for the development of a program to educate health professionals about the role and value of peer workers in improving outcomes, the training should include education on roles and outcomes achieved by the peer workforce that is supported by comprehensive evidence-based research and where possible include some combined cross sector training to broaden understanding of the role of peer workers in different clinical and non-clinical services. The MHC highlights the importance that training be co-designed and delivered by people with a lived experience and experience working and/or managing peer workforces.

Additionally, the MHC supports the establishment of regional networks of peer workers. This is happening in NSW and enables peer workers across all services to come together for support, co-reflection and professional development.

Draft Recommendation 11.7 — Attracting A Rural Health Workforce

This recommendation is a priority for the MHC. As part of the *Living Well* mid-term review consultation process, communities across NSW noted that the demand for mental health services in the community exceeds the available options, where the absence of an appropriate or accessible service, or long wait times, were frequently raised.

Workforce shortages were widely noted as a major issue within rural and remote communities with large numbers of vacancies in local teams consistently reported. Rural and remote communities experience significant workforce shortages, the lack of access to specialist mental health and drug and alcohol services was also noted as increasing with remoteness. Long term models of workforce training, formal tertiary education and support locally and from within these communities should be promoted and encouraged rather than relying on the need to provide incentives for professions relocating or the fly-in fly-out models. This enables communities to grow their workforce and allows people remain connected to the community, consequently this will encourage a more lasting workforce across hard to recruit areas. The role of on-line and telehealth modalities should also be considered where these are appropriate and effective.

Draft Recommendation 12.1 — Extend The Contract Length For Psychosocial Supports AND Draft Recommendation 12.2 — Guarantee Continuity Of Psychosocial Supports

These recommendations are strongly supported by the MHC. During the *Living Well* review the MHC found that short term funding cycles create instability across the sector which consequently have significant impacts on workforce retention and service continuity.

Draft Recommendation 13.3 — Family-Focused And Carer-Inclusive Practice

This recommendation is a priority for the MHC. The MHC is guided by the voice of people with a lived experience of mental health issues and/or caring, families and kinship groups. Family-focused and carer-inclusive care requires mental health services to consider family members' and carers' needs and their role in contributing to the mental health of the person receiving the care or support. Throughout the *Living Well* mid-term review consultation process families and carers consistently reported that they are excluded from decision-making and often remain uninformed around the needs of the person they care for. The implementation of family-focused and carer-inclusive practices will enable families and carers to participate in decision-making around the services received by the person receiving care.

Families and carers are often isolated and unsupported. To ensure the impact upon carers is reduced and their health and wellbeing is optimised, delivery of free carer support services should be strengthened and ongoing. Respite for the person receiving care, carers, family and young carers needs to be reinstated and easily available.

Draft Recommendation 16.1 — Support For Police

The MHC agrees with this recommendation and endorses the recommendation that State and Territory Governments should implement initiatives that enable police, health and ambulance services to collectively respond to mental health crisis situations. Police should not be involved in responding to people in a mental health crisis unless there is a risk to the person or the wider community, but even in these cases, there should be an accompanying mental health professional as part of the response. The MHC heard through our *Living Well* mid-term review consultation process that around half of mental health related police call outs should more

appropriately have a mental health clinician as the first responder. Further investigation of alternative approaches and models to identify who is best placed to fill the first responder role, Police or a mental health professional, and in what circumstances should be undertaken as a priority.

The MHC supports the recommendation's endorsement of the Queensland Mental Health Ambulance model. Similar models have been trialled in New South Wales. These models should be replicated around Australia as the preferred first response to mental health crisis in the community, with police response when required.

Draft Recommendation 16.2 — Mental Healthcare Standards In Correctional Facilities AND Draft Recommendation 16.3 — Mental Healthcare In Correctional Facilities And On Release

The MHC agrees with both recommendations 16.2 and 16.3. The MHC strongly supports the recommendation that the National Mental Health Service Standards should apply to mental health service provision in correctional facilities. The MHC advocates that people in custody should have access to the same quality and therapeutic standards of mental health support as that expected in the community.

Throughout the *Living Well* review consultations it was found that people in custody who have been found not guilty by reason of mental illness can wait up to four and a half years to be transferred to an appropriate forensic facility where they will receive appropriate mental health treatment. At 30 June 2019, there were 30 male forensic patients waiting in custody for a bed in the NSW forensic hospital[7].

Draft Recommendation 16.4 — Incarcerated Aboriginal And Torres Strait Islander People

This recommendation is a priority for the MHC. The MHC prioritises and recognises the leadership, views and needs of Aboriginal people and communities.

Throughout the *Living Well* mid-term review consultation process, Aboriginal communities consistently reported that they experience individual and systemic racism as well as entrenched poverty and disadvantage as a result of inter-generational trauma and grief. Aboriginal communities have significantly higher rates of incarceration and subsequent interaction with the justice system. The impact of these interactions is particularly harmful, often resulting in trauma, poor mental health and exacerbating issues of homelessness and disconnection from services and support, and from community, culture and land. The lack of culturally safe, accessible services further diminishes outcomes for Aboriginal people.

The implementation of culturally appropriate and sensitive practices will improve the experience of Aboriginal people and enable them to employ greater decision-making power and greater autonomy over the care that they receive. The MHC's findings were also consistent with those raised in the NSW Audit Office Report[4].

Draft Recommendation 20.1 — National Stigma Reduction Strategy

The MHC endorses this recommendation and encourages the National Mental Health Commission to fulfil this responsibility, and undertake this work in collaboration with the jurisdictions. Stigma interventions should look at reducing behaviours which are prejudicial and discriminating. The MHC suggests a planned approach to stigma reduction that seeks to address issues of self, social and systemic stigma will be most effective. The MHC notes that

a stigma reduction program must be evidence-informed and responsive to the community. People with a lived experience of mental health issues and caring need to be involved in the co-design and co-development of stigma reduction training programs, including those particular groups of people who experience higher levels of stigma and discrimination.

While the Productivity Commission identifies the priority to improve the stigma reduction training for health professionals, this needs to be broadened to the social and welfare service sectors. Currently the MHC is in the first stage of a Commonwealth-funded project to design a health literacy framework and resources to improve the understanding and knowledge of mental health across the workforce in LHDs (or LHNs), PHNs and the CMO sector. The development of these workforce resources aims to improve positive healthcare interactions so that the health and mental health outcomes of people are improved.

Draft Recommendation 22.4 — Establishing Targets For Outcomes

The MHC strongly supports this recommendation. In NSW the 2014 *Living Well* strategy includes a set of 10 indicators. As part of the current mid-term review of *Living Well*, these 10 indicators are being reviewed and refined to strengthen a reporting framework that takes a whole-of-person and whole-of-life approach. This work is nearing completion and the refined set of indicators will include measures focussed on the system and mental health and wellbeing outcomes for people and the community of NSW. The MHC encourages the Productivity Commission's recommendation for greater accountability for mental health outcomes to align closely with the indicators included within the refreshed *Living Well* strategy.

Draft Recommendation 22.5 — Building A Stronger Evaluation Culture

The MHC broadly endorses this recommendation, but with a significant caveat. Throughout the consultations conducted as part of the *Living Well* mid-term review, the need to focus on whole of government monitoring, evaluating and reporting on shared outcomes for people, communities (including regions) and the system (including social return on investment) was discussed. With the refined set of *Living Well* indicators public mental health services and programs should be evaluated on the basis of their outcomes. Indicators should be reportable to an agency that has authority and can encourage system accountability and work for the benefit of the people who require care.

The NSW MHC under its establishment legislation *The Mental Health Commission Act 2012*, has a legislated function to undertake evaluations under Section 12(1)(c):

12 Functions of Commission
(1) The Commission has the following functions:

(c) to review and evaluate, and report and advise on, the mental health and well-being of the people of New South Wales including conducting systemic reviews of services and programs provided to people who have a mental illness and other issues affecting people who have a mental illness, [1]

As such, while the MHC supports strengthening the role of the National Mental Health Commission in evaluation, it cannot be defined and scoped in a way that limits the legislative functions of the NSW MHC nor its independence. Therefore the MHC cautions the Productivity Commission in developing a final recommendation, to ensure that it does not limit the exercise of the MHC's legislative functions nor the voice of people with lived experience in NSW. Recognition of the NSW MHC's legislative function to undertake independent evaluations and reporting as well support for opportunities to undertake collaborative evaluation projects with

the National Mental Health Commission and other Mental Health Commissions and agencies should be clarified in the final recommendation of the Productivity Commission's report. The NSW MHC would require discussion with the Productivity Commission to have confidence in the approach taken in finalising this recommendation.

Draft Recommendation 23.3 — Structural Reform Is Necessary

This recommendation is a priority for the MHC. Under the NSW Mental Health Commission legislation[1] it is noted that an effective mental health system requires both a coordinated and integrated approach across all levels of government and the non-government sector as well as communication and collaboration between people with a lived experience of mental health issues, their families and carers, providers of mental health services and the whole community.

In the MHC's initial April 2019 submission to the Productivity Commission it was suggested that the system needs to be reoriented and realigned as the current system of services and supports is not operating as a system and consequently the outcomes for people are often poor. In addressing the question to rebuild or renovate, the MHC would encourage the Productivity Commission to consider the unintended impacts that arise from any system change. The experience of implementing the NDIS and competitive commissioning of services, for example, illustrate the reality of unintended consequences. In these examples, while overall system or program goals are to improve outcomes for people and from investment, unintended impacts were evident in: reducing access for some groups of clients; creating difficulties in navigating and accessing new systems; severing established therapeutic relationships with support workers/care providers and, creating systems that do not support people to make informed decisions.

Structural reform should be reportable through an agency that has authority to make the system accountable and work for the benefit of the people who require care. Here, the overall system redesign and the roles and responsibilities of jurisdictions will need the be clearly identified, agreed and governed to limit any unintended consequences.

Draft Recommendation 24.2 — Regional Autonomy Over Service Provider Funding

The MHC strongly supports regional decision making under this recommendation. During the *Living Well* review the MHC found that by supporting regional autonomy, funding could be allocated to services that best address regional needs. Local knowledge, expertise and community participation strengthened and informed decision making, and reflected local attributes, strengths and challenges.

Draft Recommendation 25.4 — Strengthened Monitoring And Reporting

This recommendation is a priority for the MHC. Under Section 12(1) of the *Mental Health Commission Act 2012* the MHC's functions include monitoring and reporting on mental health services and programs provided to people who have a lived experience of mental health issues and/or caring. Therefore the role scope recommended for the National Mental Health Commission intersects with that legislated for the NSW MHC. Clarity on the demarcation of roles and responsibilities is required between the two Mental Health Commissions during finalisation of this recommendation. As before, the MHC requires the Productivity Commission to exercise caution in developing a final recommendation so it does not conflict with or limit the legislated role of the NSW MHC. Additionally, opportunities for collaboration between the agencies in regard to monitoring and reporting efforts would be supported.

The MHC advocates for reform and generally endorses this recommendation's focus on reporting on outcomes, and consequently using this reporting to better address the needs of people with lived experience of mental health issues and caring. Monitoring and reporting should be reportable through an agency that has the authority to make the system accountable and work for the benefit of the people who require care.

Additional Comments

Leadership by Aboriginal People: supported as a NSW Commission Priority

The MHC advocates for choice and autonomy. Aboriginal people should be at the forefront of making decisions about their social and emotional wellbeing. However the MHC recommends that throughout the draft report leadership on reform efforts relating to Indigenous social and emotional wellbeing, mental health and suicide prevention should be formally and firmly placed in Indigenous hands and particularly, at the national level, with *Gayaa Dhuwi (Proud Spirit) Australia* – a new national indigenous social and emotional wellbeing, mental health and suicide prevention peak body. The additional leadership role of the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention in Indigenous suicide prevention should also be cemented in the final report.

The MHC supports all of the recommendations in the draft report relating to Indigenous mental health. However, there is scope for the Productivity Commission to further bolster the recommendations in its final report to better reflect the mature Indigenous leadership now operating in the mental health and suicide prevention space as signified by *Gayaa Dhuwi (Proud Spirit) Australia*. This framework has already been tasked by the Australian Government with developing an updated National Aboriginal and Torres Strait Islander Suicide Prevention Implementation Plan based on the *2013 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*.

The responsibility to implement both the *Gayaa Dhuwi (Proud Spirit) Declaration*[8] and the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*[9] is conferred on all governments in the *Fifth National Mental Health and Suicide Prevention Plan*[6].

While the draft report acknowledges the *Gayaa Dhuwi (Proud Spirit) Declaration*, it should receive greater emphasis in the final report. Indeed, this should make practical recommendations about how to infuse the mental health system with the five principles in the *Gayaa Dhuwi (Proud Spirit) Declaration* including implementing a 'best of both worlds' approach to Indigenous mental health, that supports Indigenous people's connection to culture and cultural healing and works holistically to treat the whole Indigenous person, alongside culturally safe and competent clinical services.

The draft report recognises the importance of engaging with Aboriginal people to best understand how to design and assess services which are both culturally safe and meet their needs. With the establishment of *Gayaa Dhuwi (Proud Spirit) Australia* it is essential that co-design with Indigenous stakeholders and leadership bodies is implemented. Further, all proposed policy, system and practice changes across the full spectrum of mental health and suicide prevention related activity should be considered in terms of their effect on Aboriginal people and communities. *Gayaa Dhuwi (Proud Spirit) Australia* at the national level and Aboriginal people should lead these evaluation processes. The MHC recommends the

Productivity Commission work with and be guided by *Gayaa Dhuwi (Proud Spirit) Australia* to develop these recommendations.

Section 7.1 — Consumers must be matched with the right care

The MHC supports the findings in Section 7.1 (page 279), and agrees with the statement "…which type of treatment suits a person's current needs...". However, the MHC suggests that the Productivity Commission consider rewording this sentence and emphasise individual autonomy. Rather than "suits a person's current needs" this can be made more appropriate by stating "suits person's current needs and choices", or just "suits person's current choices".

Furthermore, throughout this section the MHC suggests that the Productivity Commission further consider the role of peer workers and the role they can play in the provision of long term support and in the reconnecting of people with their recovery, their family and community, as well as work and study. Peer workers have developed these skills through their own recovery and focused education. Consumer-led peer work services can also substantially benefit people experiencing mental distress.

Page 402 - 404 — under 'Aboriginal and Torres Strait Islander health workers'

The draft report provides minimal commentary about the Aboriginal mental health and other workforces. As set out in the *Gayaa Dhuwi (Proud Spirit) Declaration*, it is critical that Aboriginal people populate both mainstream and Aboriginal Community Controlled Health Services' mental health and related areas workforces at, at least population parity levels accounting for the greater mental health needs of the Aboriginal population. The report continues to silo Aboriginal people within dedicated services rather than working towards significant Indigenous presence within mainstream services. The Commission suggests the final report should consider how to better engage Aboriginal people across the workforce spectrum, not just in identified positions.

The Commission suggests setting employment targets with population parity as a minimum goal and the introduction of accountability measures. Targets should involve both education institutions and employers. Models that support emerging professions such as the Djirruwang Program[10] at Charles Sturt University and the NSW Aboriginal Mental Health Workforce Program[5] would add value if they were supported to significantly scale up their workforce development mode.

Box 11.6 — Australian examples of peer workers

The MHC appreciates the information contained within this section however, it would like to suggest additional examples that could be included within this section. The MHC notes that peer workers have worked in NSW in large Community Managed Organisations and in public mental health services since 1993 in a variety of forms including as Peer Advocates, Representatives, Consultants and Support Workers. Consumer (peer) run peer work services such as Brook Red and Peach Tree in Queensland have a strong evidence base. There are also peer workers who are working as sole traders in the NDIS.

The MHC also recommends the inclusion of 'Next Steps Suicide Prevention Aftercare Service'[11] initiated in South Eastern NSW. Next Steps offers a combination of clinical and peer-based support to assist people at risk of suicide after being discharged from hospital or after presentation to a hospital emergency department. Peer workers are people with a lived experience of mental health issues who offer one-on-one support and understanding.

Page 391 - 393 — under 'peer workers' and 'build support for the value of peer workers'

The Productivity Commission Inquiry identified a range of issues that have hindered the development of a peer workforce and its effectiveness. The MHC would like to suggest the two following dot-points for inclusion under this section.

- Lack of significant investment in the workforce. The workforce has developed in an ad hoc, uncoordinated fashion, often without dedicated funding and consistent role descriptions and industrial classifications.
- Predominance of part-time short term contract work, making careers tenuous.

The Productivity Commission identified the role that peer workers can have in the reduction of stigmatisation of people with mental health issues. However, the MHC would like to suggest that the Productivity Commission outline and encourage organisations to involve peer workers in co-designing and delivering any anti-stigma initiatives.

Conclusion

The MHC congratulates the Productivity Commission on encapsulating the whole-of-life approach that will be required to deliver fundamental system change and subsequently improve outcomes for people with lived experience of mental health issues and caring, their families and kinship groups. The MHC suggests work could be done to strengthen the final report and the included recommendations. The MHC welcomes the Productivity Commission's report and hope that the recommendations made within can align and work alongside the refreshed *Living Well* strategy for NSW to be released in 2020. The MHC is focused on improving the mental health and wellbeing of the NSW community and in all of its work is guided by the voice of people with a lived experience of mental health issues and/or caring, families and kinship groups.

References

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