



**PRODUCTIVITY COMMISSION:
DRAFT REPORT - MENTAL HEALTH**

SUBMISSION

MENTAL HEALTH COALITION SA

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The Mental Health Coalition of SA (MHCSA) is the peak body for mental health in South Australia, has over 20 organisational members and provides a unified voice for the Community Managed Mental Health or NGO Sector in South Australia. The NGO Sector comprises non-government organisations that deliver mental health services and work with people with mental illness and their families and carers across the state. The MHCSA work includes a strong focus on supporting and growing the Lived Experience Workforce and promoting positive messages that support people to improve their well-being and reduce stigma and discrimination.

The MHCSA Vision is that all people living with mental illness in South Australia and their families will receive the mental health support they need when and where they need it. The MHCSA promotes a recovery approach which means the goal of support is to assist people living with a mental illness to build a contributing life in the community including social and economic participation.

The MHCSA acknowledges the significant effort undertaken by the Productivity Commission (PC) to understand the complexities of the mental health system. The PC is commended for recognising the crucial roles of state funded and NGO services, carers, significant others and communities.

Further, recognising and addressing vital sectors such as employment, housing and social services, further support people with a mental illness, engage in proactive supports and enable positive, sustainable recovery.

We are pleased to offer our submission to the Productivity Commission's Mental Health Draft Report, with specific consideration for the South Australian context, providing insights gained through our experience, consultation workshop (the Mental Health Coalition facilitated a workshop with representatives from Community Mental Health service providers (NGOs), the Adelaide Primary Health Network (APHN), consumers and carers) and lessons learned from across numerous reforms, changes and plans.

This submission focuses specifically on psychosocial rehabilitation supports provided by the NGO sector, and the relationships with other sectors that genuinely aid recovery for people living with mental illness and its effect on their lives.

The Productivity Commission (PC) has identified the need to deliver holistic outcomes for people including employment, education, housing, etc. The United Nations (UN) notes this challenge as the need to move from a medical model of health to a more holistic social model. Current investments in mental health in Australia are strongly shaped by medical models and this is evidenced in the Stepped Model of Care that is based on clinical intervention.

The MHCSA strongly recommends that the PC advocate for a social model of care with systems and services designed and properly funded.

The PC's Draft Report has a wide focus with many recommendations to improve the way current services are delivered and these are welcome. However, if the PC truly wants to reduce some of the economic, personal and family costs associated with mental illness, then we need to balance our current approaches with substantial investment in models that will deliver the social outcomes that the PC has identified as essential such as psychosocial supports, housing, employment and education.

The PC notes that there is a high level of unmet demand for psychosocial support outside of the NDIS. The psychosocial support options for people outside of the NDIS have reduced as a result of transfers of funds into the NDIS, resulting in the capacity to deliver the social goals identified by the PC being substantially reduced from an already inadequate base. The MHCSA recommends the PC identify the quantum of funding needed for psychosocial supports in the community to meet unmet demand, and that these are integrated with other services systems such as housing, education and employment.

Associated with this is the need for easy and timely access to services through a single access point that is reached in a variety of ways – for example acknowledging that not everyone is on-line and not everyone can manage the travel to centralised physical hubs.

A skilled workforce to deliver psychosocial supports is critical – both Mental Health Support Workers and Peer Workers in a range of roles, work within the recovery model, walking along-side people living with mental illness to support them to design and pursue a meaningful life. Peer Workers are defined as people who have lived experience of mental illness and recovery, who also possess the skill set to apply learnings from this experience into work practice. The Peer Worker model has a 25-year history, and literature suggests that Peer Workers are an important component of the mental health sector¹. The MHCSA fully supports the PC recommendation to build this workforce and develop a national Peer Workforce Peak organisation.

In this submission we propose key elements, additional to those already in the PC Draft Report, that will help us deliver on the social outcomes identified by the PC.

¹ Private Mental Health Consumer Care Network (Australia) Ltd (2018)

We highlight:

- The potential contribution, evidence and cost effectiveness of psychosocial services
- The importance of peer support
- The need to develop a psychosocial entry point to complement well-known medical and emergency pathways. This would enable people to efficiently self-direct, self-refer and access a range of information and services to support their recovery in the community
- Care coordination that is flexible enough to assist people to receive holistic support.
- Properly funded psychosocial supports that are integrated, in terms of the models, with other services such as housing, drug and alcohol services, education, employment services, other health services etc.
- Stigma reduction
- The criticality of significant lived experience involvement in co-design from policy to system and service design.

We urge the PC to look at mechanisms for providing the psychosocial support needs of the estimated 225 000² people outside of the NDIS. This investment must have a human rights-based program logic driven by recovery focused KPIs (measured at least initially using the Living in the Community Questionnaire (LCQ)). Consumer and carer experience of service surveys are also essential.

Initially, the current models could be expanded and extended to ensure they have the basic features listed above. Then models can be continuously improved as KPIs are developed and data becomes available using a co-design process driven by Lived Experience input. The risk of not addressing this psychosocial gap is the continuation of high usage levels from this cohort, of a wide range of more expensive emergency, acute, justice, welfare and social services. Additional risk for this group is greater risk of suicide with their needs left unmet and as they are responded to in an ad hoc and reactive manner; and just as significantly the higher risk of increased mortality rates as their needs remain neglected.

Finally, the Productivity Commission Draft Report identifies that successful intervention requires -

Strengthening the peer workforce through a more comprehensive system of training, work standards, an organisation to represent this workforce, and a program to build support for the value of peer workers among other health professions. (page 366).

The MHCSA would extend further by adding the need to strengthen the non-government sector/services. NGO services provide cost effective, co-designed services (which do not require crisis driven 'triage') with significant input from people with Lived Experience.

² Based on Productivity Commission model of 290,000 people in Australia needing significant support, less the 65,000 identified as eligible for NDIS.

There is clear evidence that providing opportunities for people to access psychosocial supports and services will enable targeted support that reduces the need for more expensive upstream services. The focus must include a strong emphasis on ensuring people living with mental illness are effectively supported to benefit from services they need from other systems (education, homelessness, justice system, housing).

NGO-delivered psychosocial support services are the enablers for this.

SUMMARY OF RECOMMENDATIONS

1. That the Productivity Commission determine the quantum of investment needed for psychosocial supports in Australia to adequately fund the unmet need.
2. That the Productivity Commission adopts and advocates for the need to move to a social model of care, in line with United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) recommendations.
3. The Productivity Commission advocates for a National Workforce Plan for the psychosocial support workforce that includes relevant training and practice supervision
4. A National Strategy be developed to build a nationally consistent Peer Workforce, linked to the National Workforce Plan.
5. That a National Peer Workforce Peak Body be implemented with representation in all jurisdictions, linked to the National Workforce Plan.
6. Development and investment in a national standard of care coordination/case management that works across sectors and is available in all psychosocial service settings to meet the holistic needs of individuals who need this level of support.
7. Investment be made in co-design and development (and funding) of psychosocial services in the community that support people living with mental illness to build their lives in the community with less reliance on unplanned emergency and acute care.
8. That the entry pathway for psychosocial and other supports in the community is co-designed to be accessed in multiple ways including through other service streams such as health and mental health services, housing, homelessness, AoD, education, employment services. Design must encompass the needs of different communities including Rural & Remote, ATSI, CALD, LGBTIQ.
 - a. **Note:** The Lived Experience Telephone Support Service (LETSS) is an example of an effective entry point to services and could be scaled to a national service or used as a starting point for design of a Single-Entry Point.
9. That a commissioning model is adopted that is based in a social model of care/human rights program logic. This will need to incorporate features outlined above including - a coherent entry pathway, care coordination appropriate for complexity, support for effective access to appropriate services in mental health, health and other sectors appropriate to a social model of mental health such as housing, employment etc.

10. KPIs be developed that are based on social outcomes, in line with United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) recommendations.
11. That policy, systems and services be co-designed with significant contribution (from the start) from people with lived experience as either consumers or carers.
12. That KPIs data collection and measurement be based on social outcomes as identified in the UNCRPD.
13. That in the first instance that YES and LCQ be used as measurement tools for use in local service quality improvement and national data reporting systems across jurisdictions

WHAT IS IT?

Psychosocial supports, and specifically Psychosocial Rehabilitation Supports (PRS) are collaborative, person directed, and individualised supports which aim to walk alongside and support people with a mental illness for as long as they need, to build upon their emotional, cognitive, and social skills that will enable them to design and pursue a meaningful life.

Psychosocial Rehabilitation Support is a discipline that focusses on doing with not for, by supporting people to develop their skills to manage the ups and downs on their own (with support when required) ultimately working towards the person no longer requiring supports. PRS should not be considered as therapy, medical, primary health or disability support.

Psychosocial Rehabilitation Supports are a critical partner in a shared care model that has the person living with mental illness and their carers at the centre. To take this further – it can be the hub alongside the consumer that links mental health, health and other service systems in single support or care plan.

The WA Mental Health Commission analysed their mental health spend using the National Mental Health Services Planning Framework (NMHSPF). They found underspends in all areas of mental health services from hospital beds, community mental health services (mostly clinical and mostly delivered by teams employed by the Department) and community support (mostly psychosocial rehabilitation type services and mostly delivered by mental health NGOs). Interestingly, their findings showed that whilst unmet need in inpatient settings was around 20%, unmet need was over 70% in community support³.

Investment in Psychosocial Rehabilitation Supports in the community ultimately pays for itself through increased community involvement and autonomy for people living with severe mental illness. Evaluations of psychosocial supports consistently show a reduced use of unplanned emergency and crisis care which increases the return on investment from a mental health systems perspective.

Recommendation

1. That the Productivity Commission determine the quantum of investment needed for psychosocial supports in Australia to adequately fund the unmet need.

A SOCIAL MODEL OF CARE

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) advocates a move from a medical to a social model of mental health for people experiencing mental health issues, particularly the consumers and carers with severe and enduring

³ Western Australian Mental Health Commission (2015). Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025. Perth, Western Australian Mental Health Commission. Accessed via www.mhc.wa.gov.au/media/1301/the-plan_final.pdf p.20.

experiences. A recent MHCSA/LELAN⁴ consultation with people with lived experience reinforced the UN Reports⁵ that highlight frustration with the lack of progress in investing in more holistic social models of mental health.

“A social model of care and considering the social determinants of health must factor into decisions and investments that are made for mental health, particularly as a first response and early in people’s mental illness journey. A holistic approach leads to a system that collaborates, is connected and provides the support and interventions that meet people where they are at.”⁶

The PC Report addresses a holistic approach – this needs to go beyond agencies talking to each other. For example, key issues in housing include - not enough access to public and community housing; cost of private rental and insecurity of tenure in private rentals. An additional barrier is unmet need for support for some people impacted by mental illness to access and maintain tenancies. Effective psychosocial support combined with access to appropriate housing has been proven to lead to sustainable tenancies and improved mental health (HASP evaluation 2013)⁷. We support the Productivity Commission recommendations to increase access for people more severely impacted by mental illness to safe, affordable, stable and appropriate housing stock, but note the need to increase funding for psychosocial supports in the community to help people access and maintain tenancy.

Recommendation

2. That the PC adopts and advocates for the need to move to a social model of care, in line with United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) recommendations.

⁴ LELAN is the Lived Experience Leadership and Advocacy Network in South Australia.

⁵ UN Human Rights Council (2017). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. A/HRC/35/21. Accessed via https://www.un.org/en/ga/search/view_doc.asp?symbol=A/HRC/35/21

⁶ MHCSA/LELAN Submission to the Productivity Commission Inquiry into Mental Health, 2019

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<https://www.sahealth.sa.gov.au/wps/wcm/connect/5ae1b60042ec74a389b9b99d0fd82883/HASP+Final+Report-MHSA-20130801.pdf?MOD=AJPERES>

MENTAL HEALTH SUPPORT WORKERS

Mental Health Support Workers are trained and skilled in delivering psychosocial supports. The base training is Certificate IV in Mental Health, although many have degrees and post graduate qualifications. Part of the PRS skill is being able to cross over into other domains such as housing, employment, education and the criminal justice system at times but remain focussed on the principals of empowerment, understanding the systems within which the person is needing to navigate, the ability to hold hope when the person is struggling to do so. Mental health Support Workers and their clients build a relationship that is human rights based and assist the person as they manoeuvre through the system to (respectfully) receive what they require to build and maintain a decent life.

Some Mental Health Support Workers have lived experience of mental illness and recovery; however, they may not have developed the skillset to draw from that lived experience in their role. Such lived experience is valued but not used in the overt way that a Peer Worker would.

PEER WORKFORCE

The PC Draft Report makes many references to Peer Work and Peer-led initiatives. The MHCSA feels it is important to be clear about exactly what this means.

Peer Workers are defined as people who have lived experience of mental illness and recovery, who also possess the skill set to apply learnings from this experience into work practice. The Peer Worker model has a 25-year history, and literature suggests that Peer Workers are an important component of the mental health sector⁸.

In South Australia, the roles, functions and expectations of Peer Workers vary significantly across different service types, especially between Local Health Networks (LHNs) and NGO services.

Regardless of job titles, Peer Workers generally:

- (1) Connect through lived experience – being able to draw from their lived experience while focusing on the story and needs of their client
- (2) Mentor, coach, and role-model recovery
- (3) Facilitate the achievement of recovery goals through mutuality and use of the Lived Experience skill set

Peer Workers operate from a Lived Experience skill set, essentially are trained and know how to safely use their experience. Peer Workers are not all things to all people or just people with a lived experience.

Targets for numbers of lived experience roles need to be set across the various mental health workforces. The NGO mental health workforce already employs significant numbers

⁸ Private Mental Health Consumer Care Network (Australia) Ltd (2018)

of lived experience workers; however, this workforce is currently at risk. For example, programs like Personal Helpers and Mentors Service (PHaMs) required Lived Experience roles in teams and the end of funding for this program has reduced the number of Peer Worker jobs.

The MHCSA has supported mental health NGOs in SA by developing Standards and Guidelines for NGO employers to help improve the workplace environment⁹ and workforce development tools for employers. If we lose a high proportion of the current Lived Experience workforce as appears likely, particularly with Commonwealth mental health programs being defunded, rebuilding will require specific investment in a workforce strategy to ensure high quality pathways to training and employment that are diverse and innovative. For example, the MHCSA has recently completed a feasibility study and business plan for a Peer Work Cooperative that would be owned, managed and staffed by trained and skilled people with lived experience of mental illness and recovery.

Peer Workers and Lived Experience Workers have additional challenges when employed within environments where their practice and support is confined and restricted to a clinical framework. Those Peer Work roles are often seen as sub-clinical and therefore Peer Workers in this environment are constantly challenged with walking alongside the person, exploring solutions and decisions that work for them and the system that tends to focus on clinical outcomes. This is despite evidence that suggests Peer Workers can achieve more than professional staff in some areas

“PSWs [Peer Support Workers] are better than professionally qualified staff at promoting recovery outcomes such as hope, empowerment, self-esteem and self-efficacy, social inclusion, and engagement.”¹⁰

The value of Peer Workers is not exclusive to the mental health sector, state funded services or Non-Government Organisations (NGOs). In fact, Peer Workers and Lived Experience Workers are now an emerging and evolving workforce in sectors such as Alcohol and Other Drug (AOD), homelessness, criminal justice services and first responders¹¹. The only qualification, though, remains the Certificate IV in Mental Health Peer Work.

We welcome the Commission’s view on establishing a national Peer Workforce body. To complement this, MHCSA suggests subsidised places for Certificate IV in Mental Health Peer Work, traineeships, scholarships and effective pathways into Peer Work be implemented nationally. To support this work, MHCSA and the Lived Experience Workforce Program (LEWP) have developed standards and guidelines for organisations employing Lived

⁹ MHCSA 2018. NGO Mental Health Lived Experience Guidelines. Accessed at http://www.mhcsa.org.au/wp-content/uploads/2018/12/LEW-MH-Guidelines_.pdf

¹⁰ Puschner, B et al. GlobalHealth 2019 “Using Peer Support in Developing Empowering Mental Health Services (UPSIDES): Background, Rationale and Methodology” <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6634474/>

¹¹ Shapiro, G.K. et al (2015)

Experience Workforce, that are already contributing to a national narrative including a framework and strategy.

Recommendations

3. The Productivity Commission advocates for a National Workforce Plan for the psychosocial support workforce that includes relevant training and practice supervision.
4. A National Strategy be developed to build a nationally consistent Peer Workforce, linked to the National Workforce Plan.
5. That a National Peer Workforce Peak Body be implement with representation in all jurisdictions, linked to the National Workforce Plan.

CARE COORDINATION

The Care Coordination component of the Stepped Care model (referenced by the PC) is not clear regarding the link with the unmet demand for psychosocial support for a significant cohort of people who are not the target of NDIS.

There is a considerable push, for example via PHNs, to ensure improvements in clinical care coordination between clinicians in different systems – e.g. state mental health and GPs. This is important but we argue here that there are other priorities and gaps requiring urgent attention.

The preliminary findings of our NDIS transition research has highlighted the importance of ‘case management’ delivered by state funded NGOs who deliver psychosocial support.

The MHCSA recommends investment in a care coordination model that incorporates non-clinical intervention where all service providers work in a “*peer way*¹²”; that is, providing client focussed psychosocial supports through a lens of understanding or seeking to understand the person’s whole of life experience. This utilises both a skilled psychosocial support workforce and a Peer Workforce who utilise their lived experience of mental health and recovery. Peer ways of working acknowledges the shared experience of facing and overcoming distress and adversity and building a fulfilling life despite mental illness.

Peer Workers have worked across programs and systems. If we consider their role akin to the proposed NDIS Recovery Coaches, their inclusion and increased utilisation in connection and system navigation is not diminishing the importance of clinical care coordinators, it enhances their role and the outcomes for individuals, and allows the clinical care coordinator to focus on what they do best – clinical care.

Recommendation

6. Development and investment in a national standard of care coordination/case management that works across sectors and is available in all psychosocial service settings to meet the holistic needs of individuals who need this level of support.

¹² The term “Peer Way” was mentioned by a workshop attendee who works as a Peer Worker. His observation was that all psychosocial supports should be underpinned by the values embodied in Peer Work.

EXAMPLES OF EFFECTIVE PSYCHOSOCIAL REHABILITATION PROGRAMS

Non-government organisations (NGOs) have a critical role in ensuring Psychosocial Rehabilitation Support and Peer Work within the current stepped model of care. As stated previously, the MHCSA supports changing this to a social model of care where psychosocial supports take an equal place in shared care, with the consumer and carer at the centre.

There are numerous examples where NGOs have played a critical role in the delivery of Psychosocial Rehabilitation Services:

Commonwealth funded:

The MHCSA notes the PC's Draft Report reference of several de-funded programs and would like to contribute additional insights in relation to these.

Partners in Recovery (PIR)

PIR aimed to better support people with severe and persistent mental illness with complex needs and their carers and families, by facilitating multiple sectors, services and supports to work in a more collaborative, coordinated, and integrated way.

The ultimate objective of the initiative was to improve the system response to, and outcomes for, people with severe and persistent mental illness who have complex needs.

The first report¹³ from the Partners in Recovery (PIR) evaluation and monitoring project broadly focussed on programme establishment by the 48 PIR organisations during the first year of PIR. The second report broadly focussed on early evidence of outcomes for clients as a result of PIR¹⁴. Collectively these reports highlight:

The Partners in Recovery initiative has assisted participants in areas such as housing security, physical health, psychological support, and social connection

There is significant evidence the program has created positive outcomes in a range of domains for individuals

PIR was proving to be an innovative model that was delivering transformational change for many clients with severe and persistent mental illness with multiple complex needs via a recovery-based approach that was person centred and focused on coordinating and integrating services to deliver improved outcomes.

PIR was a programme heavily dependent upon strong partnerships, taking a problem-solving approach with a low threshold for entry/eligibility and focussed on the issues from the

¹³ Urbis (2014)

¹⁴ Urbis (2015)

perspective of the person with a mental illness with no assumptions about clinical or non-clinical needs.

Personal Helpers and Mentors (PHaMs)

Personal Helpers and Mentors program (PHaMs) offered personalised support to people whose lives had been severely impacted because of mental illness. PHaMs supported people in their recovery by helping people better manage their daily living activities, reconnecting with their community and linking with other services as required.

Courage Partners reviewed several programs funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA)¹⁵

The snapshot of the PHaMs initiative highlighted:

A key element of PHaMs is its emphasis on community support and social connection as an integral component of recovery

A high proportion of clients had severe and persistent illness and had not progressed for many years until joining PHaMs

The highest representation of groups with additional needs is people with drug and alcohol co-morbidity, and people with both mental illness and an intellectual disability

The recovery approach is highly effective in engaging clients, generating their trust and empowering clients to achieve goals

Outreach services are really appreciated

Learning and applying management strategies like returning to a GP or psychiatrist, or applying what had been learned about self-management was highly valued

Social isolation was reduced

PHaMs was universally valued by community, providers and clinicians. Formal diagnosis was not required and MHCSA suggest such a program could provide a similar level of support by qualified Mental Health Support Workers and Peer Workers and access to clinical services could be facilitated in the same way as PHaMs in its pre-NDIS iteration.

Support for Day 2 Day Living in the Community (D2DL)

The Support for Day to Day Living in the Community (D2DL): a structured activity program provides funding to improve the quality of life for individuals with severe and persistent mental illness by offering structured and socially based activities and aims to support people with a severe and persistent mental illness to:

Address their social isolation

¹⁵ Courage Partners (2011)

Participate in social, recreational and educational activities

Improve their quality of life

Develop new skills and/or relearn old skills¹⁶

Healthcare Planning and Evaluation undertook an evaluation of D2DL between 2007 and 2009. Their report highlighted D2DL's achievements:

Participants consistently appeared to have experienced a severe and persistent mental illness

D2DL promoted contact with other people

Development of informal social networks among consumers

Provided opportunities to redevelop social skills and confidence

Approximately 40% showed improved functioning

Facilitated consumers to increase participation in their communities¹⁷

Other successful Commonwealth funded programs, which could form the foundation of future Psychosocial Rehabilitations Services include:

- (1) Mental Health Respite – Carers Support¹⁸
- (2) Family Mental Health Support Services (FMHSS)¹⁹

SA State funded:

Psychosocial support services funded by the Government of South Australia, through the Department of Health and Wellbeing (DHW) have achieved significant positive outcomes for people with a mental illness. The breadth of the outcomes has been, unfortunately mostly been limited to people registered with the State mental health service, not the broader community.

Individual Psychosocial Rehabilitations & Support Services (IPRSS)

The Individual Psychosocial Rehabilitation and Support Services (IPRSS) is a recovery-oriented rehabilitation and support service for people living with a mental illness. Provided to consumers of public mental health services, one-on-one support (delivered by NGOs) focuses on the areas of priority defined by the consumer.

¹⁶ Australian Government Department of Health (2017)

¹⁷ Department of Health and Ageing (2010)

¹⁸ Carers NSW: Mental Health Respite (2015)

¹⁹ Australian Government Department of Social Service

Health Outcomes International (Hol)²⁰ in 2011 produced their ‘final report’ on the evaluation of the IPRSS program. The comprehensive final report identified the non-government sector is an integral component of an effective mental health system, and concluded:

NGO providers have demonstrated an understanding of a recovery orientation and have incorporated it into their organisational culture

The IPRSS program has had a positive impact on consumer outcomes

Increased independence, improved health (both physical and mental) management, social connectedness, family relationships and improved domestic and self-care skills

The IPRSS program has had a very positive impact on the rate on mental health related hospital admissions and associated average length of stay

Crisis Respite

Crisis Respite Services (CRS) were delivered to complement the stepped model of care and provide an additional service delivery option for people with mental illness. Comprising both a residential and home based (outreach) services, Crisis Respite aimed to:

- a) Complement the stepped model of care and will provide an additional service delivery option for people with mental illness
- b) Reduce the number of emergency department presentations and or hospital admissions
- c) Reduce the burden of care experienced by carers²¹

Evaluation of the Crisis Respite service involved process and outcomes evaluation, including a cost-effectiveness analysis. The evaluation, undertaken by the University of New South Wales concluded:

The CRS has resulted in statistically significant reductions in:

Psychological Distress

Hospital admissions

Time in hospital

Emergency Department visits

Crisis Respite Care can provide substantial benefits to the well-being of sub-acute mental health consumers at relatively low

²⁰ Health Outcomes International (Hol) (2011)

²¹ Government of South Australia: SA Health (2014)

cost. CRS should be an integral part of a recovery-oriented system of provision in mental health²²

Housing and Accommodation Support Partnership (HASP)

HASP was established to link housing, psychosocial rehabilitation and clinical services to enable people with severe mental illness to live in the community and re-engage with the social, vocational and recreational aspects of their lives. Psychosocial rehabilitation is provided by NGOs, housing managed by housing providers, and the (LHN) Community Mental Health Service provides clinical assessment, treatment, crisis intervention, and both the NGO and Community Mental Health clinical services formulate a care plan. HASP has a proven track record in people being able to sustain tenancies with supports reducing over time.

Health Outcomes International (HOI) in 2013 produced their 'final report' on the evaluation of the HASP program²³. The key findings of this evaluation included:

The support delivered are considered to be of high quality

Supported consumers to improve their skills and capacity to live as independently as possible in the community

Improved consumer's quality of life, health and well-being

Avoided or reduced hospital admissions and crisis service usage

Intensive Home-Based Support Services (IHBSS)

The Intensive Home-based Support Services (IHBSS) is delivered by non-government organisations working in partnership with mental health services. IHBSS provides intensive home-based clinical and nonclinical support, case management and coordination for people experiencing mental illness following a hospital admission or who are at risk of being admitted to hospital.

Evaluated in 2015²⁴, IHBSS:

Has a proven ability to help people avoid hospital and has been a highly effective support service for people with acute mental illness

Has shown a reduction in the number of hospital admissions and hospital bed stays

Saving in reduced hospital service costs was greater than the cost of the service

²² Zmudzki, F. et al. (2015)

²³ Health Outcomes International (HOI) (2013).

²⁴ Zmudzki, F. et al. (2015)

Is not only successful in terms of its effectiveness (and cost-effectiveness) in reducing inpatient days and ED presentations. It is also an example of a successful model of inter-sectoral program development and sustainability

GP Access

GP Access is a free rehabilitation and recovery support service for people living with a mental illness who see a General Practitioner (GP).

NGOs deliver psychosocial supports, enabling GPs to concentrate on their medical/clinical work more effectively. This support not only reduces the potential time during each GP consult, it provides an added resource and support for the GP.

The value add of GP Access includes:

- (1) Providing timely support to GPs when they see people in crisis
- (2) Ensuring fewer crisis related visits to the GP
- (3) Is not limited to GP, but supports people seen by private psychologists and psychiatrists

GP Access is available to all members of the community, that is, there is no requirement that the person is registered with the state mental health system, and as such, combines elements of care coordination. In this regard it is like a PIR/PHaMs combination.

Finally, examples of positive psychosocial support delivered by NGOs are/were evident across other Australia jurisdictions. For example

- (1) Mental Health Housing and Accommodation Support Initiative (HASI) – (NSW)²⁵
- (2) Community Mental Health Transition to Recovery – (Qld)²⁶
- (3) Prevention and Recovery Care (PARC) – (Vic)²⁷
- (4) Optimal Health Program (OHP) – (ACT)²⁸

PHN funded:

Lived Experience Telephone Support Service (LETSS)

Person to person services, which assist people to navigate the system and address/explore issues of concern, are a vital adjunct to existing electronic platforms. Lived Experience Telephone Support Service (LETSS) is a good example of this and is staffed by experienced Peer Workers.

LETSS was developed to meet:

- (1) Lack of after-hours mental health services which can support and/or redirect to current services in a timely fashion

²⁵ Bruce, J. et al (2012)

²⁶ Australian Healthcare Associates

²⁷ Neami National

²⁸ Gilbert, M.M. et al. (2012)

- (2) Lack of community awareness about appropriate after-hours health care services leading to increased potentially preventable hospitalisations
- (3) Lack of community awareness about existing health care services for different population groups, consumers and providers
- (4) Lack of education of where mental health crisis support sits within a stepped care approach

Co-designed by people with a Lived Experience, as an entry point,

(LETSS) is an after-hours telephone helpline and online chat service providing non-clinical mental health support.

Peer Workers provide informed and non-judgemental support to help in times of distress and offer an alternative to attending emergency departments.²⁹

Another unique aspect of the LETSS is the follow up and wellbeing check service. Scheduled follow ups and wellbeing checks can be arranged for individuals after they have been discharged from the hospital or other mental health services³⁰

People calling LETSS receive real-time information, navigation and support in the after-hours period.

As a peer led service, LETSS has the potential to be expanded to regional South Australia or even nationally.

At the time of writing our submission, no formal evaluation of LETSS was available.

What have we learned from these services:

- (1) A linking role to support people to effectively access supports both within and outside of the mental health is vital
- (2) System design must enable early and easy access
- (3) People who are not in immediate crisis should be able to access a range of NGO supports
- (4) Alternatives to crisis services are effective, especially where the need is focussed on psychosocial support
- (5) Early access does not mean people need clinical information. If that is required, the pathways into clinical care are well known and well established. Pathways to psychosocial support are not well known, established nor accessed
- (6) People first need information, peer support, educational information, courses and psychosocial support
- (7) We need to be employing and expanding our Peer and Lived Experience workforce with a minimum qualification of Certificate IV Mental Health Peer Work

²⁹ Lived Experience Telephone Support Service

³⁰ Skylight Mental Health

- (8) NGOs provide the work environment to enable Peer and Lived Experience workers to operate effectively

In addition, MHCSA believes that a generic Peer Work qualification should be developed where students can then access a range of specialisations in addition to the current mental health offering – for example AoD, Homelessness, Domestic Violence and Forensic. In particular, for Forensic Peer Work, systems should be developed that safely enable people with lived experience of the criminal justice system to be able to provide Peer Support.

Recommendation

7. Investment be made in co-design and development (and funding) of psychosocial services in the community that support people living with mental illness to build their lives in the community with less reliance on unplanned emergency and acute care.

ACCESS TO NGO AND OTHER SERVICES

The MHCSA supports the proposed Rebuild model and the administration of Regional Commissioning Authorities (RCAs) and see these as the catalyst for national consistency and a means to bring all funding for mental health into one place.

We further support one level of government taking *full* responsibility for all psychosocial and mental health carer supports outside of the NDIS.

In relation to which level of government should establish and be accountable for RCAs, the MHCSA suggests whoever holds this responsibility must also accept full accountability and responsibility for outcomes, challenges and risks; and to do this requires a detailed understanding of the critical role of NGOs, the value of Peer Workers and Psychosocial Supports and acknowledgement of the ‘power imbalance’ that currently exist between state funded services and community services.

Addressing this imbalance is a critical first step in successfully implementing RCAs.

The MHCSA does have some reservations regarding the funding pool, noting:

The size of each RCA’s funding pool would be linked to the volume of MBS rebates for allied mental healthcare in their region and each RCA would be permitted to contract with MBS-subsidised allied mental professionals, so as to create a single budget from which all such mental healthcare in a region would be funded (page 46).

This funding focusses on ‘clinical mental health care’ and we suggest the need for a clearly defined, and appropriately funded, psychosocial stream, outside of the MBS. This will require new funding and we urge the Commission to clearly articulate the funding and

funding mechanism required to enable NGOs to deliver this unmet need for psychosocial support.

ACCESS POINTS

Current service architecture does not provide for ease (or equity) of access for consumers, is predominantly weighted towards tertiary (expensive) service provision (which are predicated on people becoming unwell before support is available), and underutilises the strengths, capacity and experience of the Non-Government sector.

The current pathways for medical, emergency and acute care services are well known but effective pathways to psychosocial supports are less well known.

For services to truly implement a *No Wrong Door* approach requires significant change to ensure that psychosocial services are more accessible and available earlier. Options for psychosocial supports need to be promoted via other service types where people with mental illness frequently present, such as GP practices, Emergency Departments, Centrelink, other service systems.

Peer Workers potentially offer significant skills and value add in these spaces. Utilising lived experience and understanding of the broader mental health system, Peer Workers can facilitate an easy connection process for, and between, these services. The LETSS service (described above) is an example of this working well.

Associated with this is the need for easy and timely access to services through a single access point that is reached in a variety of ways – for example acknowledging that not everyone is on-line and not everyone can manage the travel to centralised physical hubs.

MHCSA notes that in SA where state funding is currently provided for psychosocial supports - although delivered through NGOs, for the most part, the client group must be registered clients of the state funded mental health system and receiving clinical services. This approach limits access to these services for a significant number of people who do not require clinical support and importantly, would not be available to the majority 'outside of the NDIS'. The RCA approach could potentially address this inequity in service access within the state system if it is able to fully fund the unmet need for psychosocial supports and ensured that the models were appropriately accessible.

Recommendation

8. That the entry pathway for psychosocial and other supports in the community is co-designed to be accessed in multiple ways including through other service streams such as health and mental health services, housing, homelessness, AoD, education, employment services. Design must encompass the needs of different communities including Rural & Remote, ATSI, CALD and LGBTIQ.
 - a. **Note:** The Lived Experience Telephone Support Service (LETSS) described above is an example of an effective entry point to services and could be scaled to a national service or used as a starting point for design of a Single-Entry Point.

COMMISSIONING MODEL

Commissioning is much more than just procurement and must start with defining the need to be met before designing systems and services to respond. The risk is that some of the outcomes identified by the PC Draft Report – such as employment, housing and education – sit largely outside the KPIs of current mental health programs and services. Failure to address this mismatch will lead to failure to truly meet the needs of consumers and carers who are clear they want a more person-centred approach that takes in whole of life.

As the PC notes and tasks NMHC with, new KPIs need to be developed based on social outcomes rather than the current focus on hospital stays or hospital avoidance, with significant input from people with lived experience including carers.

Participants in our consultation highlighted the following points.

Current service design is hampered by:

- (1) Strategic planning focuses on the health sector without adequately integrating other sectors
- (2) A lack of consumer and carer involvement in developing strategy, major programs and accountability processes, lowers the quality of decision making and system performance
- (3) A continual focus on crisis, emergency and acute care means that people don't feel looked after or supported outside the acute care system
- (4) Having Emergency Departments as the 'main' entry point is highly problematic
- (5) Limited and/or poorly funded and accessible community supports to help people regain confidence, skills and problem solve, after the crisis, has not been addressed

Collectively, these highlight why the public system cannot effectively deliver person-centred, co-designed services focussing on 'people' outcomes not service outcomes.

There is a significant risk of lost opportunity to develop a more mature mental health system to realise its potential, not just in terms of health and social outcomes, but also in terms of efficacy and cost-benefit. At each stage of a reform process a workable balance is important between adequate acute/treatment services and community options that support people to maintain well-being, particularly when in crisis.

What is required is a system architecture that better targets services to meet needs, focussing on capacity building, workforce development, integration and 'fluid' movement between the community and treatment (acute). If we provide the services and support people need, when they need it, we can (for the most part) prevent the escalation to a higher level of care.

MHCSA considers the design of a future mental health system should have the following features:

- (1) System architecture that focusses on whole of person and whole of community not just 'whole of government'

- (2) Community based alternatives to many, though not all, hospital-based mental health services. These need to be psychosocial models (with clear escalation processes for people needing acute or crisis hospital care)
- (3) A trauma informed 'system' – beyond trauma informed care/support
- (4) Effective linkages between NGO, primary care, employment and social services to improve the integration of care to ensure access to services locally, including considering the needs of rural and remote communities and specific community groups
- (5) System architecture that focusses on supporting people to get well, stay well and maintain a high level of wellbeing - not simply on illness/symptoms management and treatment
- (6) A balanced system where people with a mental illness can access local services (state and NGO) as/when they require, not only when experiencing acute symptoms or crisis
- (7) Routinely measured consumer outcomes throughout all levels of service provision. Service KPI's to include measures of multiple domains of disability, impairment, functioning and quality of life; measures such as Your Experience of Service (YES) and Living in the Community Questionnaire (LCQ)
- (8) Shared Information Management Systems across state, NGO, PHN and NDIS service providers to enable shared support/care plans
- (9) Mental Health NGOs are the primary provider of sub-acute, respite and rehabilitation services that also include group activities and centres and Peer-led organisations

Any remodelling or reform in the sector must occur in collaboration, consultation and co-design with the NGO sector and consumers and carers, and programs/services like those identified earlier in our submission should not be exclusively available to consumers registered with the state/territory mental health service. With investment matching the level of unmet need, services can be designed to outreach to other settings to support people experiencing homelessness, unemployment etc.

Recommendations

9. That a commissioning model is adopted that is based in a social model of care/human rights program logic. This will need to incorporate features outlined above including - a coherent entry pathway, care coordination appropriate for complexity, support for effective access to appropriate services in mental health, health and other sectors appropriate to a social model of mental health such as housing, employment etc.
10. KPIs be developed that are based on social outcomes, in line with United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) recommendations.

CO-DESIGN

We have evidence/experiences (described above) of what a well-coordinated, person-centred mental health system, incorporating Peer Workers and balancing clinical and psychosocial support could look like.

The current mechanisms for holding jurisdictions accountable for mental health outcomes are weak and poorly developed.

The Productivity Commission's Draft Report notes:

unclear responsibilities also make it difficult for consumers and carers to hold governments individually accountable for mental health outcomes (page 889).

To remedy this, services should be co-designed with people with Lived Experience. The service architecture, KPIs and the explored outcomes, evaluation and data collection requirements for specific programs would fall out of that design.

An example of co-design that resulted in a well-designed service is LETSS (see examples of effective psychosocial programs above). Co-facilitated by MHCSA and the Adelaide PHN, the co-design team was 100% Lived Experience. The program was implemented as designed and is currently providing telephone support and supported linkages to programs and services, as an after-hours service in Adelaide by trained Peer Workforce including team leadership.

Recommendation

11. That policy, systems and services be co-designed with significant contribution (from the start) from people with Lived Experience as either consumers or carers.

DATA AND MEASURING SUCCESS

MHCSA pose the following question that underpins data collection and the measurement of success:

How do we measure that people are getting the rights services (from their point of view)?

The principles of the Commission's proposed framework for monitoring, evaluation and research are supported and nationally there is strong interest amongst the states and territories in the development of a standardised, national measure of the experiences of people accessing mental health services.

Consistent, national measures are critical to support on-going quality improvement, evaluation and benchmarking:

Your Experience of Service (YES)

Co-designed with consumer, YES gathers information from consumers about their experiences of support, identifying areas where quality improvements can be made. YES

facilitates collaboration between mental health services and consumers, ultimately building better services.

The community managed organisation (CMO) sector expressed strong interest in using the YES, however it was noted that some of the language made it not entirely suitable for CMO use. Following advice from an Expert Working Group, the YES CMO survey, and a Short Form (YES CMO SF), were subsequently developed.³¹

YES, requires a licence, and at present there is no expiration date for the licence. The Australian Government Department of Health could negotiate for this licence to be available for every NGO to implement, similar to the agreement to utilise the Camberwell Assessment of Need (CANSAS) for the Partners in Recovery (PIR) initiative.

Living in the Community Questionnaire (LCQ)

The LCQ is a validated, consumer rated, self-report tool focussing on social inclusion and recovery, exploring aspects including social activities, employment/ study, living arrangements and physical health. However, it may not fully respond to the lives of specific community groups.

Anticipated benefits of nationally consistent data collection including:

- (1) Increased consistency and KPI benchmarking
- (2) Increased ability to drive collective service improvement
- (3) Agreement on how to measure and understand 'change'
- (4) An opportunity to concentrate workforce development
- (5) Increased understanding and maximisation of information across the following level:
 - Consumer and carer
 - Service provider
 - RCAs
 - Governments

Fundamentally, to implement a nationally consistent, client outcome-based approach to data collection and evaluation, NGOs and clinical services providers should not consider data collection and measures as primarily a contractual requirement. Rather, to utilise the information to drive service improvements; to improve consumer outcomes and add value to the consumer experience of services. The proposed indicators of RCA performance are fully supported.

Recommendations

12. That KPIs data collection and measurement be based on social outcomes as identified in the UNCRPD.

³¹ Australian Mental Health Outcomes and Classification Network

13. That in the first instance that YES and LCQ be used as measurement tools for use in local service quality improvement and national data reporting systems across jurisdictions

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