Mental Health: Productivity Commission Inquiry Report, Actions and Findings: Summary

Productivity Commission 2020, Mental Health, Report no. 95, Canberra

Hospitals

- *"As a priority - To minimise unnecessary presentations to hospital emergency departments, State and Territory Governments should provide alternatives for people with mental illness, including peer- and clinician- led after hours services and mobile crisis services. (Action 13.1)"* (Safe Haven in Vic and QLD given as an example of an effective model, as well as "Crisis Now" – page 599 and Living Edge – page 599) (page 51 and 72, 599 and 628)
- Peer workers in ED are also mentioned as being able to help with de-escalation and liaising (page 603). Positive results have been shown by Next Septs Suicide Prevention Aftercare Service of reductions in depression and anxiety (page 604)
- It is recommended that: "State and Territory Governments should provide more and improved alternatives to hospital emergency departments for people with acute mental illness, including peer- and clinician-led after-hours services and mobile crisis services." (page 204)
- It is suggested that there could be an expanded role which peer workers could play in hospitals – with people in hospitals provided access to LE for support and advocacy, and to navigate services and systems (page 612) and culturally specific services (page 613)

GPs

- It is noted that GP MH training should include attitudes to peer workers and highlighted that this is a barrier to more widespread use of peer workers. Seed funding from the government is recommended to create a LE professional association (also mentioned on page 713):
    - *"Peer workers — people employed on the basis of their lived experience of mental illness — are well placed to support people with mental illness during their recovery. Indeed, evidence to the Inquiry made it clear that this type of assistance was highly valued by people with mental illness. The nature of the experience and training required to allow peer workers to be most effective and the circumstances in which they can best be included, is the subject of ongoing work in the sector. A barrier to more widespread use of peer workers is the acceptance of their role by clinicians. A program to build support among clinicians for the role and value of peer workers should be developed and implemented in collaboration with the relevant professional bodies."*
    - The Australian Government should strengthen the peer workforce by providing once off, seed funding to create a professional association for peer workers, and in collaboration with State and Territory Governments, develop a program to educate health professionals about the role and value of peer workers in improving outcomes. (Action 16.5) (page 75)
    - It is noted that peer workers are underutilised and there are risks of shortages in MH nurses (page 699)

Marginalised populations

- Peer workers noted as being positioned to play a major role in assisting CALD cultural and language barriers (Page 176), as well as helping address workforce shortages (page 188), especially for those outside of mainstream – e.g. CALD, LGBTIQ (page 176) and new parents (e.g. by guiding them through screening opportunities for MH challenges page 200)
- While it is acknowledged that LE can play a pivotal role in schools (e.g., page 234), it is highlighted that education systems are overwhelmed with a range of MH support services.

- Peer support networks are mentioned on page 341 in terms of work based (e.g. mates in construction) and helping in EAPs. Notes that the effectiveness depends on culture.

Benefits and Barriers

- Noted benefits and barriers (page 392):
    - Peer workers who provide voluntary support for people with mental illness are likely to experience benefits in terms of their confidence, self-esteem, and recovery (Kilpatrick, Keeney and McCauley 2017). However, literature regarding peer workers in paid employment cautions that care needs to be taken to ensure their own mental health and wellbeing is maintained (Holley, Gillard and Gibson 2015).
    - Australian and Swedish studies have found that the peer support provided within the Clubhouse setting can contribute to improved self-esteem and promote recovery (Coniglio, Hancock and Ellis 2012; Schon 2010) (page 393)
- The importance of LEW for a person-centred MHS is detailed on page 726 +, noting that while there is evidence of their benefits, they need to be used more effectively. A lack of metanalysis studies is noted (page 727).
- Barriers noted are on page 728, then followed by a detailed discussion of each:
    - Insufficient recognition of the value of LEW
    - Inadequate supervision and support
    - Poor PD and career pathways
    - Absence of a professional body
- It is noted that seed funding from the government should be given for a professional body and that later in the future a program should be developed to improve education about LEW.

Data/stats/terminology/Quals

- Data inadequacies noted on page 701 but estimated 56000 FTE clinical practitioners, 20000 paid peer and community MH workers. – page 701. A need for better data is mentioned on page 706
    - *"There is no estimate of the total number of peer workers in the mental health system. The evidence available suggests they currently play a role in State and Territory specialised mental health services — with 184 consumer peer workers and 69 carer peer workers (in FTEs) in these settings in 2017-18 (AIHW 2020b, table 34). However, there are many more peer workers employed by non-government service providers. For example, Flourish Australia (sub. 330, p. 5) employs about 200 peer workers across their services. Across New South Wales alone, it has been estimated that peer workers comprise about 11% of direct support roles in community managed organisations (MHCC and HCA 2019). The Queensland Lived Experience Leadership Roundtable (sub. 799, att. 3], p. 26) point to a 10-fold increase in peer workers across Metro South Addiction and Mental Health Services. In New South Wales, the expansion of the peer workforce is one of the key reforms to come out of Living Well: A Strategic Plan for Mental Health in NSW 2014 – 2024 (Wellways, sub. 396, p. 9)." (page 725)*
- Definitions given for consumers and carers only, combined roles not mentioned – page 702
- Noted that community MH workers and LEW are not registered and while skilled, some have no qualifications.
- The roles are outlines in chapter 16.4 where it goes into detail on pages 724-725 about the unique position due to experience, the different pathways and that they are a relatively new workforce. Australian examples are given on page 726 including Flourish, etc.

Carer workers

- It is noted that Carer workers should be used to full positions when possible to improve the workforce capability for family and carer inclusive practices. "*Several Inquiry participants*

supported the use of carer peer workers in mental health services to promote carer-inclusive practice (Anne Barbara, sub. 910; Mind Australia, Melbourne transcript, p. 35; MHCN, Sydney transcript, p. 97; St Vincent's Mental Health Family and Carer Reference Committee, sub. 1193)." Page 899

Table 18.3 **Carer peer workers employed in state and territory specialised mental healthcare facilities, 2017-18[a]**

State or Territory	*Count of FTE carer peer workers*	*FTE carer peer workers per 100 000 people in the population*	*% of specialised mental health service organisations employing at least one mental health carer*
New South Wales	3	—	11
Victoria	35	0.6	55
Queensland	24	0.5	45
South Australia	5	0.3	57
Western Australia	1	—	3
Tasmania	1	0.1	27
Northern Territory	0	0.0	0
ACT	0	0.0	0
Australia	**69**	**0.3**	**27**

[a] Carer peer workers are defined as persons employed specifically for their expertise developed from their lived experience as a mental health carer. Carer peer workers employed in the community managed sector are not included. — rounded to zero.

Source: AIHW (2020h, tables FAC.34, FAC.36 and FAC.5).

- It is estimated that part of the cost of recommended reforms to improve family and carer inclusive practices includes $26-29 million per year for additional peer workers.
    - Further, the NMHSPF estimates that in 2019-20 it would cost $154 million to provide family and carer support services that meet the needs of the community, including $17M for individualised and group-based carer peer work
- Examples of successful carer peer work is on page 903