

Submission to the  
Productivity Commission Inquiry into Mental Health

Brisbane North

Peer Participation in Mental Health Services (PPIMS) Network



*Nothing about us without us*

April 2019

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## Acknowledgements

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This submission was prepared collaboratively by PPIMS via consultation and follow-up engagement. We are grateful for their input, which is recorded here and provided the basis for this response. Without them we could not have done it. We also especially thank PPIMS members Stephen Brown for allowing us to include his own very thoughtful and informed submission as attachments to this document, Tina Pentland for sharing parts of her submission to this paper and her editorial support, and Louise Byrne for her knowledge, experience, and practical and emotional support to the network over several years.

Lastly, a big thank you to Paula Arro whose belief in us is an inspiration to everyone.

PPIMS Secretariat - Contact

Paula Arro – Consumer and Carer Participation Coordinator

## Preamble

The Productivity Commission inquiry into mental health in Australia is a unique opportunity to change the way governments, organisations and systems respond to the needs of the countless individuals who suffer mental ill health year by year, and in consequence fail to reach their potential or find purpose and meaning in their life. For many such individuals, this can mean being on an endless roundabout of clinical interventions, over-reliance on bad medicine, poor physical health, likely contact (or worse) with the criminal justice system, social isolation, unemployment, homelessness, a life-sentence of poverty and early death. In other words: no recovery. The lives of families and carers are in many instances equally void of quality and happiness due to the stresses—financial, emotional, physical and mental stressors they have to bear. From this perspective, the needs of carers largely parallel the needs of consumers. Finding ways to promote mental good health and wellbeing for everyone, therefore, will lead to a healthier and happier society, and at the same time meet the primary objective of this inquiry, namely: *supporting social and economic participation, and enhancing productivity and economic growth*.

This submission by the Peer Participation in Mental Health (PPIMS) network, as a collaborative endeavour, focuses on the importance of **participation** as a path to recovery, that is, enabling people with a lived experience of mental ill health, including families and carers (PLE), to take ownership of their lives and create their own path. PPIMS recognizes that this objective can be achieved in a multitude of ways, and includes the following aims in its terms of reference: supporting a strong peer workforce in mental health; supporting others in work or study; giving people opportunities to network and form friendships; and promoting consumer and carer participation and engagement across all sectors of government and non-government organisations.

The submission is organised as follows. First, some background to the PPIMS network is given followed by a brief description of the processes involved in developing the submission. Second, the individual comments of PPIMS members, obtained through consultation, are provided as a framework for the recommendations and summary that follow.

## Background

The Peer Participation in Mental Health Services (PPIMS) network was formed to be a voice for people with lived experience (PLE) in the Brisbane North region. During the three years since its formation, PPIMS has been a strong support to PLE in Brisbane North by developing strong links to the community and community organisations, working with government and non-government organisations, collaborating in research statewide and nationally, and many other projects. In 2018, members of the PPIMS Network contributed through a robust and collaborative consultation process to the Regional Plan, *Planning for Wellbeing*, sponsored by Brisbane North PHN (BNPHN) and Metro North Hospital and Health Service (MNHHS), in which PLE, including families and carers, are acknowledged as essential leaders of change.

The purpose of the network, as the name suggests, is to enable **participation** for everyone and to ***work collaboratively to actively participate in mental health systems and reforms***. To achieve this objective, the network facilitates activities that provide a voice for PLE in the Brisbane North region, improve PLE engagement, provide information on current and emerging issues, and encourage participation in co-design opportunities through consumer and carer representation and engagement.

In summary, the PPIMS network:

- Supports PLE who want to actively participate in the mental health system reform process and/or are accessing mental health services;
- Provides opportunities to have regular updates and input around services, policy, and program and system developments;
- Provides opportunities to have regular updates and identify strategies to improve engagement, participation, training and employment opportunities.
- Provides advice on emerging issues faced by consumers and carers in the mental health sector; and
- Encourages participation in co-design opportunities that arise through the PHN or other government and/or non-government services.

Membership of the PPIMS network comprises community members, peer workers, general mental health workers who are also PLE, volunteers, PLE trainers, educators, students and academics, and committee representatives. PPIMS collects quarterly membership data that assists in identifying who we are as a network and highlighting members' special interests or areas of expertise that is an important resource for future projects, programs and research.

PPIMS meetings are held monthly in two locations, at the PHN Lutwyche and North Lakes offices, to cater for members who live across a large region extending from inner Brisbane areas to Moreton Bay and beyond. PPIMS supplies regular updates and information about

jobs and opportunities to participate in mental health reforms at local, state and national levels via a mailing list of over 300 subscribers.

Recent activities sponsored by PPIMS have included scholarship programs for PLE (e.g., Certificate IV in Mental Health) and showcasing projects at a local, state, national and international forums/conferences. In June 2018, PPIMS members have presented to over 140 attendees from 29 PHNs across Australia at the National Stepped Care Workshop hosted by Brisbane North PHN.



In April 2019, the PPIMS network is celebrating its three-year anniversary, and is proud of the support it has been given by Brisbane North PHN via secretariat, meeting venues, and other on-going supports. In recognizing the importance of the collective knowledge and experience of PLE, the PHN has empowered the PPIMS network to be a strong and independent collective voice in the region.

### **Lived experience led research**

Key to best practice mental health service delivery, is the meaningful, well-supported embedding of peer/lived experience roles as a valued part of the wider workforce. However, lived experience roles are largely still under-supported, poorly understood and lacking positions of authority with which to advocate for change. It is essential that processes like the productivity commission take into account the ongoing development of lived experience workforce. This includes understanding both the existing challenges and identified strategies for best practice. There is substantial research to support this, primarily led by Dr Louise Byrne, a PPIMS member and currently a Vice-Chancellor's Postdoctoral Fellow at RMIT

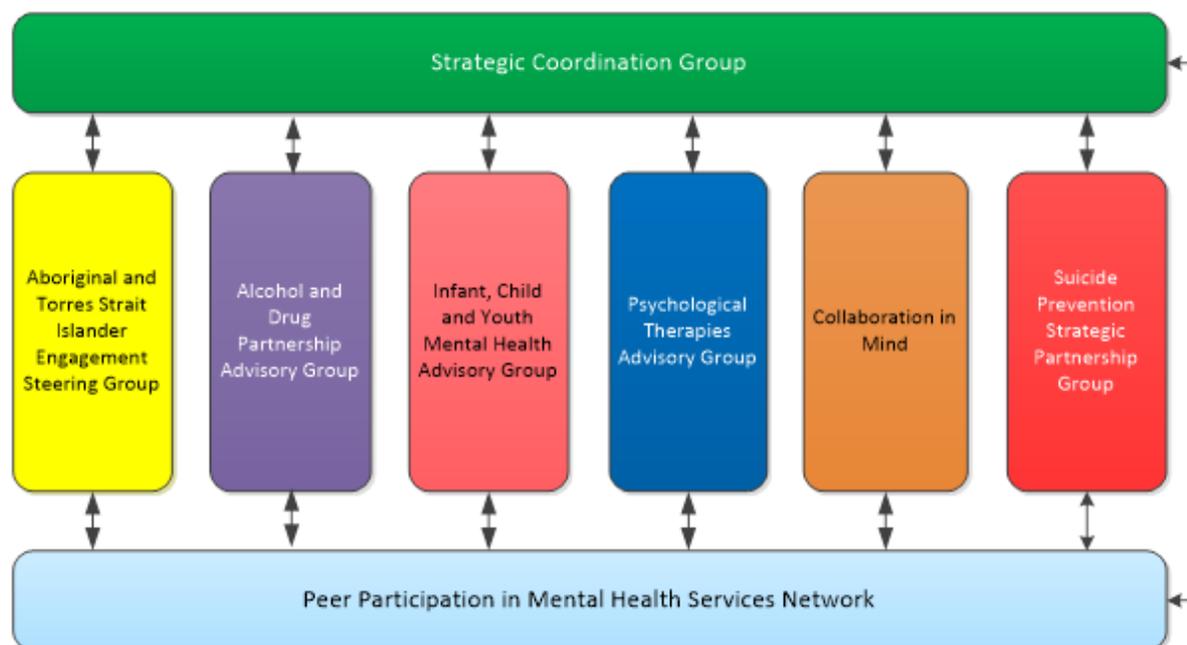
University, who has been carrying out research on lived experience and work since the early 2000s. Her work, which includes 30 peer-reviewed journal publications, several book chapters and numerous industry publications, focuses mostly on the perceived value and workforce development needs of lived experience roles. Louise's program of research represents the most comprehensive study of lived experience work certainly in Australia and possibly internationally. In considering the ongoing development of lived experience roles in this country, it is essential that Louise's work is consulted. Some of her work is listed in Attachment 1. Louise's full body of work is available at [https://www.researchgate.net/profile/Louise\\_Byrne2](https://www.researchgate.net/profile/Louise_Byrne2)

### Co-design: policy and planning

PPIMS has been actively involved over the last three years building a network of diverse and specialist lived experience and is currently involved in range of local, state and national strategic-level planning. The Brisbane North Mental Health Alcohol and other Drugs regional planning committee (led by BNPHN and MNHHS) delegated resources to PPIMS to develop a lived experience section in the Regional Plan.



PPIMS is also clearly identified in the governance and oversight of the implementation phase of the plan. There is representation from PPIMS on all partnership and governance groups within BNPHN.



The most significant work currently being undertaken by PPIMS is building relationships, partnerships and a collaborative environment where there is a commitment to PLE leading change. The successful implementation of our Regional Plan—in particular, that people with lived experience lead change combined with better support for family and carers—must be addressed in this inquiry. (Table 1)

*Table 1. Priority areas and objectives identified by PPIMS for the Regional Plan*

PRIORITIES	Consultation feedback	Shared objectives
<b>PLE leading change.</b>	<ul style="list-style-type: none"> <li>▪ ‘nothing about us, without us’</li> <li>▪ strengthen the collective voice of PLE</li> <li>▪ make it easier for PLE to be active partners in all stages</li> <li>▪ make services accountable to PLE</li> <li>▪ must support each other and be informed</li> <li>▪ need stronger participation and collaboration mechanisms</li> <li>▪ strengthen participation of PLE workforce and in strategic roles</li> </ul>	<ul style="list-style-type: none"> <li>✓ strengthen/diversify a ‘collective voice’ of PLE to drive it</li> <li>✓ make available training and capacity building for PLE</li> <li>✓ active participation in planning, delivery and evaluation</li> <li>✓ establish/sustain a region-wide approach to participation</li> <li>✓ advocate for peer workforce development</li> <li>✓ expand and diverse LE workforce across all levels of employment</li> </ul>
<b>Supporting families and carers.</b>	<ul style="list-style-type: none"> <li>▪ carers not included, supported and welcomed by service providers</li> <li>▪ communication between service providers and carers is lacking</li> <li>▪ financial hardship experienced as a result of caring role</li> <li>▪ carers not clear on benefits those they care for are entitled to</li> </ul>	<ul style="list-style-type: none"> <li>✓ provide information, resources and skills to support carers</li> <li>✓ better care for families and carers</li> <li>✓ families and carers are listened to and involved in services</li> <li>✓ services are more responsive to the needs of people and carers</li> </ul>

## Development of the Submission: Collaboration and Collective Action

The Issues Paper of the Productivity Commission, released in January, was circulated through the PPIMS network and service providers to advise that here was an opportunity to have input to this significant inquiry. In February, the Commissioner and staff attended a PPIMS meeting to provide further information about the inquiry, answer questions, and seek out some early feedback from members.

### What we heard from the Commission

Dr Stephen King (Commissioner) and Lawson Ashburner (economic researcher) attended as guest speakers at the quarterly combined PPIMS meeting held in Chermside on 12 February. They provided background information on the work of the Productivity Commission and explained the purpose of this inquiry as described in the [Issues Paper](#), and provided a list of focus questions based on the Issues Paper (Attachment 2). This information, summarised below, was also circulated in meeting notes to those members not able to attend on the day:

- The Productivity Commission (PC) is an independent statutory organisation, government funded but independent of government (i.e., government doesn't control its output). The Commission has a mandate to do their own research; however, the government may from time to time ask the Productivity Commission to carry out inquiries (e.g., the [NDIS cost report](#)).
- The inquiry process begins with talking to people from the community followed by: submissions > bringing it together > recommendations > draft report > feedback > help to implement the recommendations. The Commission aims for practical recommendations that the government can implement.
- Governments cannot 'bury' reports/recommendations, but they can ignore them.
- Members of the Productivity Commission are micro-industry economists who look at an industry or a market and identify what is/is not working; what are the gaps; what needs to change; and they ask questions like: Is this policy helping or hurting?
- Recommendations could be anything from tweaking around the edges or starting again.
- Any submissions to the inquiry are de-identified as they are posted on the website.

## Overview of the inquiry: ToR, issues and objectives

The Terms of Reference for this inquiry include: (1) cost; (2) looking at how services work together to provide appropriate care (integration); and (3) is the current system working as well as it could? Questions and issues relevant to the inquiry (before submissions) include:

- Why are economists involved in the Mental Health inquiry, not clinicians? (Productivity Commission)
- The current system is not designed with the needs of people and families at its core. (Allan Fels, [Letter to the Prime Minister](#), November 2013)
- The mental health debate becomes clinical and governments do not have that specialist knowledge.
- Mental health is more than clinical; it has economic and social costs.
- Governments work with budgets: mental health costs are obvious, but the benefits are not.
- What is the cost to other parts of the system when there are gaps in mental health service provision (e.g., housing, workforce, carers, etc.)?
- The Productivity Commissions Report will have weighting and will be beneficial to both the sector and consumers/carers.
- What is the cost benefit? If you spend the money today what are you saving in the future?
- Early intervention and prevention is a big issue: spend \$\$ early to not spend \$\$ later.

## Input from PPIMS

### Some initial thoughts shared by PPIMS to the Commission

The Commission was wanted to hear in these early stages of the inquiry people's thoughts on any information they had so far. PPIMS agreed to consider the information provided on the day and follow up with discussions in a closed group. Some key areas that network members felt the Commission needed to focus on are summarised below:

- Workplace health and safety
- Stigma and discrimination

- HHS recovery model vs NDIS: the NDIS is not designed for episodic mental health; currently constrained by the NDIA directive that mental unwellness must be experienced every single day
- Alternatives to hospital admission
- Peer work is the way to the future: acute hospital settings do not help people get better
- Some staff/organisations take longer to embrace peer work than others
- How are PLE being supported to work? (This relates to culture of organisations to support PLE and their families; the importance of work to reduce poverty and promote wellness)
- External peer supervision—not clinical supervision—career pathways current hot topics
- Eligibility for services
- The need for peer and consumer operated services
- How do you quantify mental health cost?
- Need to be talking about **lost opportunity if we do nothing** and **investment rather than cost**

At the conclusion of the meeting, members agreed to put in a submission from PPIMS to be facilitated by a working group. Put in submission on behalf of PPIMS—working group to facilitate this and others not at the meeting to be invited. Additional new resources developed at a national level were included in the meeting notes for those interested to have a look (and/or those not in attendance on the day) including:

- [Sit beside me, not above me](#) (n.d., National Mental Health Commission, Consumer and Carer Engagement Project)
- [Shifting gears: Consumers transforming health](#) (2018, Consumers Health Forum of Australia [White Paper])

## Issues

At the March PPIMS meeting, the list of questions and themes that the Commission were looking into were provided to members and discussion and posting of comments undertaken. One member came with their thoughts already on paper and gave consent for this to be included in this submission and shared with the PPIMS network. (See Attachment 3)

Feedback from this meeting is summarised below.

### **STRUCTURAL WEAKNESSES IN HEALTH CARE**

- *more alternatives to ED/HHS*
- *psych facilities are not 'well' spaces for people*
- *need for more out of hours services and facilities*
- *need to improve GPs' knowledge of what options there are for people; they need more training in working with people with mental health issues; the person is the expert in their own mental health yet there is still a power dynamic with GPs*
- *need more spaces for mutual support and capacity building*

### **SPECIFIC HEALTH CONCERNS**

- *need to be more proactive/preventative/early interventions*
- *Wheel of Wellbeing, Wise Choices, DBT, ACT, alternative therapies and other peer-led initiatives funded and increased across the region*
- *more options for skilled peer support workers*
- *gaps in services between childhood and teens (8–15 years)*
- *better access to alternative medicine and therapies (e.g., Chinese medicine)*

### **HEALTH WORKFORCE AND INFORMAL CARERS**

- *increase the lived experience workforce*
- *subsidised training, scholarships and sponsorships for people with a lived experience to participate*

### **HOUSING AND HOMELESSNESS**

- *create a holistic approach on discharge, not just referral to mental health services*
  - *do they have somewhere to go?*
  - *do they have a support person?*
  - *are they linked in with housing support services?*
- *explore options of housing stock and vacant public buildings, venues and spaces*
- *look at New Zealand government and their procuring of housing stock and wrap-around services*
  - *are there other lessons to be learnt internationally?*
- *do people in hospital and other services feel confident and empowered to raise concerns about becoming homeless?*
- *process of applying for housing is so difficult and huge waiting lists*
- *need more affordable housing options in longer term, not just short-term shelters*

## **SOCIAL SERVICES**

- *now nowhere to refer with PiR and PHaMS ceasing*
- *current services in challenging times, especially staff leaving and fewer support coordinators available*
- *rural and remote issues*
- *need to increase rental assistance options*
- *mutual support funding gone from health services, therefore those not case managed are missing out on access to social service supports*
- *reactive not proactive social service responses*
- *need for more safe space options*
- *more funding for centre-based and outreach support available through self-referral*
- *more programs for life skills capacity building*

## **SOCIAL PARTICIPATION AND INCLUSION**

- *group programs, life skills teams, places to connect with people and more safe spaces*
- *groups for social activities, paid peer coordinators*
- *centre-based groups and activities focused on recovery with options for individual support*
- *how can people who are not eligible for NDIS access and be supported to participate in activities?*

## **JUSTICE**

- *past history impacting on people becoming lived experience workers (eg., criminal history check, blue card)*
- *Independent Patient Rights advocates*
- *alternatives to incarceration for people with mental health issues*
- *expansion of the co-responder program between QPS, QLD Health and QAS*
- *will restorative justice culture be considered or implemented?*

## **CHILD SAFETY**

- *fear of implications if needing to access services and mandatory reporting*
- *need more supported detox options*
- *teaching kids around AOD and mental health issues in age-appropriate way*
- *child abuse and neglect: is there evidence that the public health and child safety models are working?*
- *complete overhaul of the child safety system*

## **EDUCATION AND TRAINING**

- *more affordable DBT programs and fewer/shorter waiting lists*
- *school-based identifications of signs of developing mental health issues and where to go for help*
- *normalising mental health experience through conversations and sharing of lived experience and recovery*
- *psychological support services in schools*
- *group workshops on wise choices, DBT, Wheels of Wellness*
- *proactive mental health programs part of standard education curriculum at all levels of education system.*

## **GOVERNMENT-FUNDED EMPLOYMENT SUPPORT & GENERAL EMPLOYMENT SUPPORT TO EMPLOYERS**

- *empower clients to follow their preferred field of study*
- *employ lived experience workforce as employment service officers*
- *combine DSP with employment providers*
- *more flexible KPIs with job placements: currently not person-centred*
- *encourage and support people to follow what they love doing (not menial tasks such as toilet cleaning!!)*
- *campaign to encourage employers to support and employ people with lived experience*
- *current system gives \$\$ for 6 months only; need some longer term options*

## **MENTALLY HEALTHY WORKPLACES & REGULATIONS OF WORKPLACE HEALTH AND SAFETY**

- *time-out spaces*
- *mentors and opportunities to debrief, supports for workers beyond EAP*
- *policies outlining commitment to support employees and not discriminate, including reasonable adjustment policies*
- *more workplace flexibility, e.g., working from home, alternatives for people with chronic pain, leave entitlements for mental health days*
- *Mental Health First Aid training to staff and management*
- *having an identified peer wellness staff member (apart from generic HR) to go to in confidence and without stigma attached*
- *more mental health training and awareness offered by people with a lived experience of mental health issues and recovery to break down stigma*

## **COORDINATION AND INTEGRATION**

- *more transparency between departments*
- *more empowering/less risk adverse practices*
- *state/territories (e.g., HHSs, Commissions) and national programs (e.g., PHNs, DoH) working better together in co-contributing and leveraging off existing effective programs.*
- *not separate funding pools as is currently happening with the NPS funding*
- *more flexible eligibility requirements across programs: people don't care who funds what, they just want access to services that would be easier via hubs/one-stop shops*

## **MONITORING AND REPORTING OUTCOMES**

- *more personal recovery vs clinical recovery outcome measures*

## **Summary**

The PPIMS network has worked in the Brisbane North region for the last three years to promote participation across the sector, and to be a resource for PLE so that they can truly be agents of change.

The issues raised by PPIMS members outlined above highlight the serious gaps and inconsistencies in mental health that exist at every level still today in Australia. The changes that need to be made for tangible benefits to occur fall into the following main categories and actions:

- Person-centred, holistic health
- Peer workforce
- Individual empowerment and integrity
- Reduce poverty
- Build houses
- Create healthy working environments
- Listen to people

## Attachments

### Attachment 1: Journal articles relating to Lived Experience Workforce Development

Dr Louise Byrne is a PPIMS member. Louise's work is informed by her own experiences of mental health diagnosis, service use and periods of healing. Louise has worked in lived experience specific positions since 2004, in a variety of lived experience roles across the mental health and higher education sectors, including the first full-time lived experience mental health academic role in Australia, and as an expert advisory role to the Queensland Mental Health Commission in 2015.

Louise is currently employed as a Vice-Chancellor's Postdoctoral Fellow at RMIT University, in the School of Management. Louise was awarded a Fulbright Postdoctoral Scholarship in 2017 to conduct research on lived experience employment in the United States. During her Fulbright research, Louise was a visiting scholar within the Yale Program for Recovery and Community Health. Louise is currently leading the development of a Framework for Lived Experience Workforce Development, funded by the Queensland Mental Health Commission.

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#### Further reading

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## **Attachment 2: Commission Questions**

### **QUESTIONS ON ASSESSMENT APPROACH**

- What suggestions, if any, do you have on the Commission's proposed assessment approach for the inquiry? Please provide any data or other evidence that could be used to inform the assessment

### **QUESTIONS ON STRUCTURAL WEAKNESSES IN HEALTHCARE**

- Why have past reform efforts by governments over many years had limited effectiveness in removing the structural weaknesses in healthcare for people with a mental illness? How would you overcome the barriers which governments have faced in implementing effective reforms?
- What, if any, structural weaknesses in healthcare are not being targeted by the most recent and foreshadowed reforms by governments? How should they be addressed and what would be the improvements in population mental health, participation and productivity?

### **QUESTIONS ON SPECIFIC HEALTH CONCERNS**

- Should there be any changes to mental illness prevention and early intervention by healthcare providers? If so, what changes do you propose and to what extent would this reduce the prevalence and/or severity of mental illness? What is the supporting evidence and what would be some of the other benefits and costs?
- Which forms of mental health promotion are effective in improving population mental health in either the short or longer term? What evidence supports this?
- What changes do you recommend to healthcare to address the specific issues of suicides and comorbidities among people with a mental illness? What evidence is there to support your suggested actions and what types of improvements would you expect in terms of population mental health, participation and productivity?
- What healthcare reforms do you propose to address other specific health concerns related to mental ill-health? What is the supporting evidence and what would be some of the benefits and costs?
- What overseas practices for supporting mental health and reducing suicide and comorbidities should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?

### **QUESTIONS ON HEALTH WORKFORCE AND INFORMAL CARERS**

- Does the configuration and capabilities of the professional health workforce need to change to improve where and how care is delivered? If so, how should the workforce differ from current arrangements? How would this improve population mental health, participation and productivity?
- What can be done to address health workforce shortages in regional and remote areas? In which areas or circumstances would greater use of technology and tele-health services be suitable? What prevents greater remote provision of services to address the shortages?

- What restrictions exist on the scope of practice for different professions, such as GPs, nurses, clinical versus other psychologists, and social workers? Are these restrictions unwarranted and, if so, how could they be addressed and what would be some of the costs and benefits?
- What could be done to reduce stress and turnover among mental health workers?
- How could training and continuing professional development be improved for health professionals and peer workers caring for people with a mental illness? What can be done to increase its take up?
- What changes should be made to how informal carers are supported (other than financially) to carry out their role? What would be some of the benefits and costs, including in terms of the mental health, participation and productivity of informal carers and the people they care for?

#### **QUESTIONS ON HOUSING AND HOMELESSNESS**

- What approaches can governments at all levels and non-government organisations adopt to improve:
  - support for people experiencing mental illness to prevent and respond to homelessness and accommodation instability?
  - integration between services for housing, homelessness and mental health?
  - housing support for people experiencing mental illness who are discharged from institutions, such as hospitals or correctional facilities?
  - flexibility of social housing to respond to the needs of people experiencing mental illness?
  - other areas of the housing system to improve mental health outcomes?

What evidence can we draw on to assess the efficiency and effectiveness of approaches to housing and homelessness for those with mental ill-health?

What overseas practices for improving the housing stability of those with mental illness should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?

#### **QUESTIONS ON SOCIAL SERVICES**

- How could non-clinical mental health support services be better coordinated with clinical mental health services?
- Are there significant service gaps for people with psychosocial disability who do not qualify for the NDIS? If so, what are they?
- What continuity of support are State and Territory Governments providing (or plan to provide) for people with a psychosocial disability who are ineligible for the NDIS?
- Are the disability support pension, carer payment and carer allowance providing income support to those people with a mental illness, and their carers, who most need support? If not, what changes are needed?
- Is there evidence that mental illness-related income support payments reduce the propensity of some recipients to seek employment?

- How could mental illness-related income support payments better meet the needs of people whose capacity to work fluctuates over time?

#### **QUESTIONS ON SOCIAL PARTICIPATION AND INCLUSION**

- In what ways are governments (at any level) seeking to improve mental health by encouraging social participation and inclusion? What evidence is there that public investments in social participation and inclusion are delivering benefits that outweigh the costs?
- What role do non-government organisations play in supporting mental health through social inclusion and participation, and what more should they do?
- Are there particular population sub-groups that are more at risk of mental ill-health due to inadequate social participation and inclusion? What, if anything, should be done to specifically target those groups?
- What indicators are most useful to monitor progress in improving mental health outcomes through improved social participation and inclusion?

#### **QUESTIONS ON JUSTICE**

- What mental health supports earlier in life are most effective in reducing contact with the justice system?
- To what extent does inadequate identification of mental health and individual needs in different parts of the justice system increase the likelihood, and extent, of peoples' future interactions with that system?
- Where are the gaps in mental health services for people in the justice system including while incarcerated?
- What interventions in the justice system most effectively reduce the likelihood of re-offending, improve mental health and increase prospects for re-establishing contributing lives? What evidence is there about the long-term benefits and costs of these interventions?
- What are the main barriers to lowering the over-representation of people living with a mental illness in the justice system and what strategies would best overcome them?
- To what extent do inconsistent approaches across states and territories lead to inefficient, ineffective or inequitable outcomes for offenders and their families?

#### **QUESTIONS ON CHILD SAFETY**

- What aspects of the child protection programs administered by the Australian, State and Territory Governments are the most effective in improving the mental health of people in contact with the child protection system?
- What, if any, alternative approaches to child protection would achieve better mental health outcomes?

#### **QUESTIONS ON EDUCATION AND TRAINING**

- What are the key barriers to children and young people with mental ill-health participating and engaging in education and training, and achieving good education outcomes?
- Is there adequate support available for children and young people with mental ill-health to re-engage with education and training?
- Do students in all levels of education and training have access to adequate mental health-related support and education? If not, what are the gaps?
- How effective are mental health-related supports and programs in Australian education and training settings in providing support to students? How effective are programs in educating staff, students and families, on mental health and wellbeing? What interventions are most effective? What evidence exists to support your assessment?
- Do teachers and other staff in schools and education facilities receive sufficient training on student mental health? Do they receive sufficient support and advice, including on the quality and suitability of different approaches, to adequately support students with mental ill-health?
- What overseas practices for supporting mental health in education and training should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?

#### **QUESTIONS ON GOVERNMENT-FUNDED EMPLOYMENT SUPPORT**

- How cost effective have the Australian Government's Disability Employment Service (DES) and Personal Helpers and Mentors service (PHaMs) been in enabling people with a mental illness to find and keep a job? Have the DES and PHaMs been targeted at the right populations?
- What alternative approaches would better support people with a mental illness (whether episodic or not) to find and keep a job?
- To what extent has the workforce participation of carers increased due to the Australian Government's Carers and Work Program?
- What will the transition to the NDIS mean for those receiving employment support?
- Which State or Territory Government programs have been found to be most effective in enabling people with a mental illness to find and keep a job? What evidence supports this?
- How could employment outcomes for people experiencing mental ill-health be further improved?

#### **QUESTIONS ON GENERAL EMPLOYMENT SUPPORT TO FIRMS**

- What examples are there of employers using general disability support measures (through supported wages and assistance to provide workplace modifications) to employ people with a mental illness? How could such measures be made more effective to encourage employers to employ people with a mental illness?
- Are there other support measures that would be equally or more cost effective, or deliver improved outcomes?

#### **QUESTIONS ON MENTALLY HEALTHY WORKPLACES**

- What types of workplace interventions do you recommend this inquiry explore as options to facilitate more mentally healthy workplaces? What are some of the advantages and disadvantages

of the interventions; how would these be distributed between employers, workers and the wider community; and what evidence exists to support your views?

- Are employers pursuing the potential gains from increased investment in workplace mental health which have been identified in past studies? If so, which employers are doing this and how? If not, why are the potential gains not being pursued by employers?
- What are some practical ways that workplaces could be more flexible for carers of people with a mental illness? What examples are there of best practice and innovation by employers?
- How can workplace interventions be adapted to increase their likelihood of having a net benefit for small businesses?
- What role do industry associations, professional groups, governments and other parties currently play in supporting small businesses and other employers to make their workplaces mentally healthy? What more should they do?
- What differences between sectors or industries should the Commission take account of in considering the scope for employers to make their workplaces more mentally healthy?
- Are existing workers' compensation schemes adequate to deal with mental health problems in the workplace? How could workers' compensation arrangements, including insurance premiums, be made more reflective of the mental-health risk profile of workplaces?
- What overseas practices for supporting mental health in workplaces should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?

#### **QUESTIONS ON REGULATION OF WORKPLACE HEALTH AND SAFETY**

- What, if any, changes do you recommend to workplace health and safety laws and regulations to improve mental health in workplaces? What evidence is there that the benefits would outweigh the costs?
- What workplace characteristics increase the risk of mental ill-health among employees, and how should these risks be addressed by regulators and/or employers?

#### **QUESTIONS ON COORDINATION AND INTEGRATION**

- How effective are the governance and institutional arrangements for mental health in Australia in achieving the objectives agreed by COAG Health Council in the Fifth Plan? How can they be improved?
- To what extent do current governance and institutional arrangements promote coordination and integration of mental health services and supports across health and non-health sectors and different levels of government?
- What are the barriers to achieving closer coordination of health, mental health and non-health services and how might these be overcome?
- Is the suite of documents that comprises the National Mental Health Strategy effectively guiding mental health reform? Does it provide government and non-government stakeholders with clear and coherent policy direction? If not, what changes could be made?

- Are there aspects of mental health governance where roles and responsibilities are unclear or absent? Are the mechanisms for holding government decision-makers accountable for system performance sufficiently well-defined?

#### **QUESTIONS ON FUNDING ARRANGEMENTS**

- What have been the drivers of the growth in mental health expenditure in Australia? Are these same forces likely to continue driving expenditure growth in the future? What new drivers are likely to emerge in the future?
- Can you provide specific examples of sub-optimal policy outcomes that result from any problems with existing funding arrangements?
- How could funding arrangements be reformed to better incentivise service providers to deliver good outcomes, and facilitate coordination between government agencies and across tiers of government?
- Are the current arrangements for commissioning and funding mental health services — such as through government departments, PHNs or non-government bodies — delivering the best outcomes for consumers? If not, how can they be improved?
- How does the way the Medicare Benefits Scheme operate impact on the delivery of mental health services? What changes might deliver improved mental health outcomes?
- What government services and payments beyond those directly targeted at mental health should this inquiry seek to quantify, and how should this be done?

#### **QUESTIONS ON MONITORING AND REPORTING OUTCOMES**

- Are decision-making forums for mental health receiving high quality and timely information on which to base strategic decisions?
- Does Australia have adequate monitoring and reporting processes to assure compliance with national standards and international obligations?
- Is there sufficient independence given to monitoring, reporting and analysing the performance of mental health services?
- Which agency or agencies are best placed to administer measurement and reporting of outcomes?
- What does improved participation, productivity and economic growth mean for consumers and carers? What outcomes should be measured and reported on?
- What approaches to monitoring and reporting are implemented internationally? What can Australia learn from developments in other countries?
- To what extent is currently collected information used to improve service efficiency and effectiveness?

### Attachment 3a: Submission by Stephen Brown

The Treasurer's reference to the Productivity Commission on Mental Health is both complex and diverse and appears to cover a continuum of events across clinical recovery and personal recovery a domain of fluidity (Issue Paper).

As a qualified social worker with experience as a consumer, carer and advocate I wish to raise the following issues:

1. Research opportunities exist for consideration of a social context at a 360 degree perspective and should include social needs, social rights and social citizenship impacts of political economy inclusive of social determinants of health and social determinants of health inequalities. Clearly one needs to define mental health as inclusive, collaborative, positive and open in nature.
2. The diversity of mental health and mental illness personal and clinical contexts require more than a response of medicine alone or the politics of psychiatry.
3. All sectors of political, social, economic, community and family life require reference as no man or woman is an island.
4. The social consequences of policy, structure, process and style are significant as models should see that 360 degree interaction, collaboration and inclusion and avoid or reduce discrimination and stigma.
5. Mental health for most is personal, family and community related and finally social construction of a critical perspective should draw an understanding (knowledge) and action (decisions) beyond a narrow clinical define. It is paramount to draw a understanding of the person in environment, community and family as carer and advocacy roles are significant.
6. A parting thought is the need to distribute and/or redistribute well-being fairly and with equity not to disadvantage the worst more.

Policies on age, gender differences, housing need action to attend to social citizenship as current distributions across fiscal and occupational welfare leave many at sea. Redistribution at a well-being level is badly needed. Indeed welfare has become a two tier system. Inclusion at a citizenship level needs greater consideration of equality of opportunity and equality of outcomes indigenous people here are badly unrepresented at the well-being level.

Structural gaps at age and gender level fail many, yes we must employ young people but not exclusively at the cost of other and yes I see these as different labor markets

I believe we start with:

1. Agreement that personal recovery of mental health is a journey of small steps and personal differentiated this does not preclude or exclude the key driver of focus here. I agree both economic and social engagement is needed. The social determinants of health and health inequality however currently remain in the division, access and capacity of current employment structures of full time, part-time, casual, contract and term practices. I agree impacts occur on income, living standards, social engagement and connections and that this is limiting, discriminatory and exclusive.
2. The best opportunity appears to be in the Primary Health Network with the purpose and intent to work with the Stepped care model in a recovery perspective. In this model I am seeing positive communication across both clinical and personal recovery.
3. Final note all sectors including those within the mental health sphere of action need a realignment of the taxation-welfare systems.

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