

The Commissioners
Productivity Commission Inquiry into Mental Health
Locked Bag 2 Collins Street East,
Melbourne VIC 8003

Dear Commissioners

On behalf of GROW Australia, thank you for the opportunity to appear at the public hearing on Tuesday 3 December 2019 and for the opportunity to make this submission to the Draft Report on Mental Health. GROW considers the Draft Report provides a substantial basis for reform albeit there are issues of substantial importance which still need to be dealt with.

In particular, GROW is extremely concerned at the lack of understanding or recognition of Peer Support in the Commission's draft, even though Peer Support has been an evidence-based cornerstone of the Australian mental health system for decades.

A worrying example is that the Commission has totally removed peer support from the proposed Stepped Care model. This suggests to us that the Commission has wrongly viewed Peer Support as being about a workforce, whereas it is about a model of support which is fundamental to the Australian mental health, alcohol and other drugs and suicide prevention systems.

Evidence developed over many years – both in Australia and internationally – shows that Peer Support or Intentional Peer Support is low cost but highly valued by consumers as it helps people to recover, reduces social exclusion, keeps people out of hospital, taking their medication, enables them to form relationships and build community, reduces suicidality and helps them gain and retain employment.

From GROW's point of view, this is a glaring omission which needs to be rectified.

GROW also highlights for the Commission's consideration the evidence provided below about the impact of our Get Growing Peer Support services, delivered in schools, which are proving to be highly effective in getting students at risk to attend school and stay in school. Get Growing also meets the objectives of the National Curriculum in relation to Personal and Social Capability and thereby lessens the burden on principals, teachers and families.

Currently there is a relative 'over representation' of the 'whole of school or class' approaches to mental wellbeing and the relative ease of delivering those programs (with very indirect outcomes) versus the more challenging approach of organised Peer to Peer Support for students identified as in need and the associated direct accountability/action/outcomes. GROW considers that the Commission should aim to rebalance investments in student health and wellbeing to provide for a significant increase in in-school Peer to Peer programs for students identified as at risk in recognition of the demonstrated value these programs bring.

Our response below expands on the issues raised above and my presentation to the public hearing, as well as addressing a number of other issues raised by the Draft Report, and we would be delighted to discuss these issues further. We wish you all the best in finalisation of the Report.

Yours sincerely

David Butt
National CEO
23 January 2020

GROW Australia

Response to Productivity Commission Draft Report

Recommendations and solutions

1. The Final Report of the Productivity Commission should recognise the social and economic value of Peer Support/Peer to Peer Support as fundamental to high performing mental health, suicide prevention and alcohol and other drugs systems.
2. The Commission should confirm and publish definitions of the differences between Peer Workers on the one hand and Peer to Peer Support (or Intentional Peer Support) on the other, to end confusion on the differences between the two:
 - The two are often used interchangeably but they are quite different things
 - Peer Workers or paid peer support is a service which is provided to help someone – to do something for or to another
 - Peer to Peer Support or Intentional Peer Support is focused on building a healthy and meaningful relationship, on learning together and building community where there are mutual benefits for all involved – it is two-way
 - Both provide value: indeed, there is decades of evidence about the value of Intentional Peer Support (see below) – however they represent very different approaches.
3. The PC should include in its report the evidence that investment in Intentional Peer Support is a vital element of helping people to recover, reducing social exclusion, keeping them out of hospital, taking their medication, enabling them to form relationships and build community, reducing suicidality and helping them gain and retain education and employment.
4. Intentional Peer Support services should be strengthened and expanded so that all people who want and need such a service get the opportunity to access such a service.
5. The role of Intentional Peer Support should be reinstated in the stepped care model presented by the Commission (Figure 4.1, Volume 1, p189) just as it is included in the *PHN Primary Mental Health Care Flexible Funding Pool Programme Guidance – Stepped Care 2019*¹:
 - It is highly concerning that the Commission Draft Report has removed Peer Support totally from the Stepped Care model when the Commonwealth guidance identifies Peer Support for Levels 3, 4 and 5 of the stepped care model – through the Moderate Intensity, High Intensity and Acute and Specialist Community Care steps
 - Peer Support also should be identified for Step 2 – Low Intensity services
 - It is assumed the Commission has removed peer support because as identified above and elsewhere there is a lack of understanding that Peer Support is a model of service rather than a workforce
 - Peer Support should be presented in the model just as *Online navigation platforms for service providers* is presented – it should be stretched across the Figure from Levels 2 to 5
 - The change to the title of the various steps – from “service” as used in the Commonwealth guidance, to “care” as proposed in Figure 4.1 – should be reversed, to move away from the very strong clinical flavour of the Draft Report and recognise the importance of non-clinical services and supports.

¹ Commonwealth of Australia 2019, [https://www1.health.gov.au/internet/main/publishing.nsf/Content/2126B045A8DA90FDCA257F6500018260/\\$File/1.%20PHN%20Guidance%20-%20Stepped%20Care%20-%202019.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/Content/2126B045A8DA90FDCA257F6500018260/$File/1.%20PHN%20Guidance%20-%20Stepped%20Care%20-%202019.pdf)

6. To support students at risk to go to school and to stay at school, the value of Peer to Peer Support among students should be promoted by the Commission as a low cost, non-judgemental, strength based role modelling approach which empowers students to help themselves and help others, and successfully supports those most at risk.
 - Currently there is a relative ‘over representation’ of ‘whole of school or class’ approaches and the relative ease of delivering those programs (with very indirect outcomes) versus the more challenging approach of organised Peer to Peer Support for students identified as in need and the associated direct accountability/action/outcomes
 - GROW considers that the Commission should aim to rebalance investments in student health and wellbeing to provide for a significant increase in in-school Peer to Peer programs for students identified as at risk in recognition of the demonstrated value these programs bring
 - GROW’s Get Growing 10-week schools based program helps schools and teachers achieve the objectives in the National Curriculum and lessens the burden on principals, teachers and families
 - The Mission Australia 2019 Youth Survey found 83.0% of young people will go to their friend/s for help with important issues in their lives compared to:
 - Parent/s or guardian/s (75.2%)
 - Teachers (36%)
 - School Counsellor (30%)
 - Community services (12.9%)²
 - Funding should be identified in school wellbeing budgets to enable facilitated Peer to Peer Support programs for those identified as at risk.
7. On system Governance, GROW supports an expanded commissioning role for PHNs and a focus in the final report on ways to improve the renovate model, including:
 - Evidence at a regional/service level (from all LHNs) that funding allocated to LHNs for mental health and suicide prevention has been spent on mental health and suicide prevention
 - Increased accountability and public reporting on progress on co-commissioning by LHNs and PHNs
 - Clear accountabilities for LHNs and PHNs to demonstrate engagement and participation with consumers, carers and other service providers in co-design, planning, commissioning, delivering services and monitoring and evaluating performance
 - A services planning agenda which sets funding/percentage targets for increasing investment in prevention, early intervention and primary health care
 - Targets for increasing funding to strengthen the role of the non-Government sector in prevention and early intervention, as well as in helping to cover the “missing middle”
 - Targets for reducing the need for hospitalisation and ED presentations
 - Consistent contractual arrangements across Australia from PHNs/LHNs: if there are to be multiple funders (and there always will be), the cost to service providers should be minimised by ensuring consistency in contracts, terms, and reporting, with consistent longer contract terms to provide greater certainty for organisations and their staff
 - Reporting on high quality and comparable performance data for monitoring performance.
8. Any changes to the role of Mental Health Commissions should recognise and ensure that the effectiveness of commissions, at the state or national level, lies in their capacity to influence decisions made by government. Three particular instances which require protection and reinforcement are: engagement across government, promotion of the consumer voice, and specific mechanisms to protect human rights.

² Carlisle E., Fildes, J., Hall, S., Perrens, B., Perdriau, A., and Plummer, J. 2019, Youth Survey Report 2019, Sydney, NSW: Mission Australia <https://www.missionaustralia.com.au/what-we-do/research-impact-policy-advocacy/youth-survey> Accessed 22 January 2020.

9. Require monitoring agencies such as the National Mental Health Commission to use and analyse existing data effectively by setting clear reporting requirements
 - To improve comparability and analysis of data (including over time), a consistent approach to data collection should be adopted, not just across all health jurisdictions but also across related portfolios which impact on mental health and wellbeing e.g. education, employment, housing, justice and social services
 - For example, at a minimum, that consistent approach should cover age ranges across the lifespan (0-4; 5-11; 12-17; 18-24; 25-34; 35-44; 45-54; 55-64; 65-74; 75-85; 85+)
 - This can already be done by many collection agencies (AIHW, ABS) but that data is not being used to full effectiveness for monitoring and reporting purposes by agencies such as the NMHC
 - When detailed analysis is undertaken of existing (but often unreported or unanalysed) data, the indicators overwhelmingly demonstrate the rise of mental ill-health among children and young people, particularly in the age range 15-24. In some instances, proportions and rates are higher among those 25-34: after that, proportions and rates tend to reduce by age.
10. Consider the use of Intentional Peer Support as an alternative to Low Intensity Therapy Coaches and psychological therapists.
11. Examine Intentional Peer Support as a cost effective alternative to attendance at an Emergency Department
 - Such services need to be set up separate to the hospital ED e.g. in Safe Haven Cafes.
12. Increase support for the wellbeing and role of carers and families of people with mental illness by improving access to carer-specific Peer Support which has been proven to enable carers to share their experiences, learn from each other and support each other.
13. Extend the recommendations on mental health in correctional facilities and on release to cover youth aged 10-17 under youth justice supervision in Australia.
14. Expand Peer Support services to cover all correctional facilities as a way of both supporting people with a mental illness while in prison and as transition support into Intentional Peer Support on release.

1. GROW Australia: a model of Intentional Peer Support

GROW was established in 1957 and is the original prototype of a program which was designed and led by people with lived experience. Decades before buzz words like co-design and co-production were being bandied around, the GROW program was designed by consumers and delivered by consumers, and that still remains the case today.

Across Australia, GROW plays a special role:

- Many people with mental illness find themselves isolated and estranged from family, friends and the community, and without the resources to engage in the kind of critical thinking that can help them maximise their quality of life.
- Formal mental health services are not designed to provide the kind of social support, friendship, role models and community that is important to mental health recovery.
- Without opportunities to engage in critical thinking within a trusted social group, and to interact socially, it is difficult to sustain a pathway to recovery.

GROW works on a model of Peer Support, or Peer to Peer support (often called Intentional Peer Support) and continues to provide leadership in this area across Australia whether through the classic Grow group programs, or newer programs such as Get Growing in schools, eGrow, online forums, young adults programs, specific programs for carers and prison inmates, and residential recovery programs for people with a dual diagnosis of mental illness and substance misuse.

GROW has helped tens of thousands of people to recover from severe mental ill-health using an evidence-based approach to peer support. This involves GROW's distinctive services of fostering personal leadership, mutual help, peer support, self-activation leading to self-actualisation and ultimately recovery.

Each week about 1500 people with mental illness – many with quite severe illness – meet in small groups across Australia, or via online eGrow services, and go through a structured program which aims to give them a community in which they belong, a structure where their lives often otherwise have none, a way forward to grow and recover, to keep them out of hospital, at home participating in the community and as far as possible productive at work.

You don't need to have a diagnosis – even though most people do have one – you don't need a medical referral, although we are engaged in integrated care pathways, for example, in acute mental health units where our field workers with our consumers meet with inpatients and provide them with information on what we do, and the opportunity to join a group – a way forward after their hospitalisation.

People with lived experience need to be provided with a greater ability to choose organisations such as GROW which create a space for growing into a safe but challenging community providing leadership and modelling around being a better community member by addressing their own mental health and helping others do the same. This is particularly the case when an increasing focus on individual case management and NDIS packages has changed the approach of traditional service providers so that many have become increasingly clinical or only interested in you if you have a package and hence people feel they don't belong there anymore – it has become 'closed off' in their words.

The existence of places like GROW is important for those falling through the cracks as well as those very isolated individuals who choose this group peer type approach.

2. Recognising Intentional Peer Support and the difference with Peer Workers

GROW is extremely concerned the draft report confuses or misses the difference between Peer Support and Peer Workers. In some ways, this is not surprising: terms such as “Peer Support”, “Self Help”, “Peer Workers” and “Consumer-led services” often are used interchangeably. However, they are very different types of intervention and it is important for the Commission to recognise this in its final report.

This is particularly relevant given the Commission’s Draft Finding 20.1 — that social exclusion is associated with poor mental health. GROW’s programs were specifically designed by people with lived experience to overcome the problems of social exclusion and to build community among people in need.

Peer Workers are a valuable addition to the workforce and GROW supports proposals for recognising and strengthening their roles. However, there is a fundamental difference between Peer to Peer or Intentional Peer Support on the one hand and the practice of employing Peer Workers or Peer Staff in traditional or new mental health programs and services.

Peer developed and led Peer Support (as practiced by GROW for the past 62 years) is a non-hierarchical approach to support and recovery – indeed described by its founders as non-democratic in that power or authority is not passed over to any individual or governing body. It is a grass-roots movement founded in social inclusion, self-help and mutual support, and based on principles of equality, respect, mutual learning and growth, empathy, understanding, shared responsibility, building functional relationships and community, and obligation to yourself and each other – recognising that while each person’s experience is individual there are shared experiences of emotion, distress and loss of power and place.

Peer Workers on the other hand, who are employed in existing or new roles in mental health programs, generally do not provide “peer support” as this term is commonly understood by users and practitioners of traditional peer support. They bring to their role their lived or living experience of mental ill-health and provide services and support to people who are living their experiences. They substitute for an existing member of the mental health team or are an addition to that team.

- “One of the things that differentiates us from other kinds of Peer Support – at least paid Peer Support – is that the intention is to focus on building a healthy and meaningful relationship as opposed to the focus of service, which is for me to help you, and the focus is also on learning together as opposed to helping which assumes problems and that to me is fundamentally different than other services.”³
- “Peer support has been recognised as an essential component of a supportive network for persons with severe mental illness and the empirical base of studies of peer delivered services has grown.”⁴
- “Regarding mutual-help groups or self-help groups, all of the studies examined the outcomes for participants of peer-support groups because there is usually no clear distinction between the providers and the recipients of peer support in mutual-help groups. As Solomon and Draine pointed out, people working in peer-operated services and peer employees provide services to others; benefits for themselves from their work are secondary. In contrast, people in mutual-help groups expect mutual benefit and are unpaid.”⁵
- “As Mead said, “When people find others who have had similar challenging experiences, there is almost instant connection (finally someone who really gets it). But the real gift in peer support goes beyond initial affiliation. The real gift lies at the intersection of true reciprocity and the exploration of

³ Shery Mead, Founder of Intentional Peer Support, YouTube 10 June 2014 https://www.youtube.com/watch?v=Q1w_HGQWTiU
Accessed 17 January 2020.

⁴ Myamoto, Y. Sono, T. Lessons from Peer Support Among Individuals with Mental Health Difficulties: A Review of the Literature. Clinical Practice & Epidemiology in Mental Health, 2012.

⁵ Ibid

new meaning and possibility.” Armstrong *et al.* reported that peer-support recipients and volunteer partners (peer-support providers) emphasized that the focus of their interactions was not their shared psychiatric histories but rather their relationships as empathetic human beings. These studies show that reciprocity and empathetic human relationships are the important aspects of peer support. It is crucial to consider how empathetic human relationships can be built and to challenge conventional attitudes about providing support. To accomplish these goals, it may be necessary to redefine the concept of help and support and the ‘professional attitude’.”⁶

In summary:

- **Peer Support** is a mutual, bi-directional relationship-based approach with a philosophical basis in the potential for mutual growth and healing, and with clear principles and practices reflecting equality and respect⁷
- **Peer Work** as increasingly practiced in traditional and new mental health programs is not a peer-to-peer relationship given that in common usage a “peer” is an equal: “Relationships between peer staff and service users are usually hierarchical, similar to staff-service user relationships generally within the mental health system, in contrast to the horizontal relationships that characterize peer-developed peer support”.⁸

2.1 Value

Is the service valued by the consumer? Most certainly. Over many years, GROW has undertaken surveying of participants which shows that the program helps people to recover, reduces social exclusion, keeps people out of hospital, taking their medication, enables them to form relationships and build community, reduces suicidality and helps them gain and retain employment.

GROW also has undertaken comprehensive literature reviews and an action research project to identify the most robust theories about mutual self-help in mental health recovery, evidence-informed best practices in peer support for mental health, and potential measurement tools.

The literature reviews show the evidence from a huge cluster of far reaching studies demonstrate high satisfaction as well as positive outcomes and sustainability of recovery from mutual support groups. There were 45 studies of effectiveness of mutual support for a diverse range of conditions which showed improvement in psychosocial wellbeing, knowledge, mastery and coping (Kyrrouz, Humphreys, Loomis 2002).⁹

⁶ Ibid

⁷ Penney, D. Defining “Peer Support”: Implications for Policy, Practice, and Research, Advocates for Human Potential 2018

⁸ Ibid

⁹ Kyrrouz, E., Humphreys, K., Loomis, C. A Review of Research on the Effectiveness of Self-Help Mutual Aid Groups 2002. http://www.bhrm.org/media/pdf/recovery/KyrrouzHumphreys_2002.pdf Accessed 19 January 2020.

GROW's latest annual survey of participants remains open. However, to date there have been 380 responses which is statistically significant. The report on those responses is at *Attachment A*. A summary of responses shows:

GROW's latest survey:

- 85% of participants have been diagnosed with a mental illness
- 70% of participants are on medications
- 63% had been hospitalised for their mental illness (more than 10 times for 22% of them)
- 62% have had thoughts about attempting suicide
- 32% had self-harmed
- 22% had experienced homelessness
- Childhood trauma was the largest factor contributing to their mental ill-health, followed by poor relationships with family and relationship breakdown.

Participation in GROW had helped:

- 46% recover from mental illness
- 51% overcome suicidal thoughts
- 29% stop suicide attempts
- 30% needing fewer hospitalisations and 31% not needing to be hospitalised
- 55% cooperate with professional help while under treatment
- 55% have significantly less need for professional help
- 16% no longer need professional help
- 25% reduced their need for prescribed medications
- 9% no longer needed medications
- 16% to gain employment
- 21% to gain employment
- 18% to change job/career
- 20% to stop self-harming
- 19% to manage or overcome drug and alcohol problems
- 8% to reduce contact with the justice system
- 15% to obtain or maintain stable housing

Personal feedback from participants in the 2019-20 survey includes the following:

2019 Grow Australia Member Survey - Q18 Quotes



What keeps you coming back to Grow?

" I want to give back to the types of people who helped me so much during some of the darkest and most frightening times in my life. "

The companionship of friends. Learning leadership skills. Working towards achieving worthwhile goals.

... I'm not so ashamed of having a mental illness

" A shared sense of friendship and camaraderie. The opportunity to, one day perhaps, help others through the Grow Program. "

That its my safe place each week to come to.

... the actual Grow Program of personal growth. The friendships I have made in Grow. I believe Grow saved my life. Grow has a healing effect on my life.

" I want to recover and help others in their recovery "

... keeping myself clean (drug free) for myself and my family. I was discharged the first 5 weeks the first time here in NSW. I followed the structured program on the outside, and was let back in after only 4 weeks. Now I'm 3 months clean, doing very well thanks to staff and the program. I will succeed in life and help others. Thanks Grow.

The programme gets into your DNA. I enjoy Grow meetings, on the whole. They're uplifting and, of course, I keep going to Grow to assist others to help themselves. "Carry the message, not the person." We never stop Growing!

" Trying to understand my mental health and know I am not alone "

... Ive got no where else to go, Ive tried everything else and there is no time limit, I can just keepworking away at it, its a slow process and I'm a slow learner and I just love grow.

" When I was supported back into ongoing employment, I continued attending although my symptoms were stable & intrusive negative thoughts had abated. I choose to continue attending as a way of 'giving back' and supporting other Growers. "

" Knowing that i have value in my life and help me to realize that i am unique person. Who can stand up for herself and say no "

2019 Grow Australia Member Survey - Q37 Quotes



What other ways has Grow helped you?

“ Grow has provided me with a group which gives me social interaction. Grow has given me hope and it is good for normalising mental illness. ”

• ...Stopped me using street drugs completely and start my life •

To be more durable than vulnerable!

I feel I have gained wisdom knowledge and hope. I feel the process is assisting me in self empowerment

“ ...to live a nearly normal life ”

I've stopped isolating, stepped out and stepped up (after working through the anxiety of putting myself 'out there'; the fear of having to do it all by myself. Grow has helped me speak up to get my needs met without feeling guilty about having needs; has helped me be 'ordinary' within my uniqueness; and I am better able to accept every other human being.

“ ...Grow was extremely helpful in overcoming suicidal thoughts and loneliness early on and in understanding mental illness and controlling thoughts ”

“ Regaining confidence that I am a person with worth. ”

... I feel less ashamed and isolated, about my mental health, as I feel comfortable to share with a group of people. The Structure is very beneficial, practical tasks and readings. I can't thank the Grow movement enough.

Grow involvement always helps me focus on the positives in my own life and I get enormous joy in seeing and being a part of the growth in others.

“ Yes, before and after I released from prison, like links with community and support and not feel alone by my self and support my mental illness. ”

“ Grow has taught me to forgive myself and to be a better person. ”

... Grow encouraged me to get my car licence which I now successfully have. And I have also been encouraged to work in a job. Most of all to feel accepted.

“ Grow has provided me with a group which gives me social interaction. Grow has given me hope and it is good for normalising mental illness. ”

3. Peer Support is a fundamental component of a Stepped Care model

It is of considerable concern that the Draft Report removes the current recognition of peer support as a fundamental component of a stepped care approach to mental health and wellbeing by taking it out altogether from the amended stepped care model which has been proposed (Figure 4.1, Volume 2, p189).

This is completely at odds with the *PHN Primary Mental Health Care Flexible Funding Pool Programme Guidance – Stepped Care 2019*¹⁰. GROW can only assume this has occurred because of the lack of understanding by the Commission as identified above that peer support is a model of service rather than a workforce.

The Commonwealth guidance identifies Peer Support for Levels 3, 4 and 5 of the stepped care model – through the Moderate Intensity, High Intensity and Acute and Specialist Community Care steps: at all three levels it proposes “community supports such as peer support, social participation or lifestyle interventions”. GROW considers peer support also should be identified in the stepped care model for Level 2 – Low intensity: participation in GROW’s programs occurs from people across the spectrum of mental ill-health.

Peer Support should receive the same treatment in the model as *Online navigation platforms for service providers* – it should be stretched across Figure 4.1 from Level 2 to Level 5.

GROW also recommends that the change to the title of the various steps – from “service” as used in the Commonwealth guidance, to “care” as proposed in Figure 4.1 – should be abandoned, as this proposed change adds to the strong clinical flavour of the Draft Report and instead the model should continue to recognise the importance of service, including non-clinical services and supports.

4. Low intensity does not equal low levels of mental ill-health

As identified above, people across the spectrum of mental ill-health – from low to moderate intensity, high intensity and acute and specialist community mental health services – need low intensity services such as Peer to Peer support (including face-to-face and online support): low intensity does not equal low levels of distress, illness, depression or anxiety nor does it mean minimal impact or outcome.

A stepped care approach should relate to functional impairment, not to diagnosis i.e. It should relate to the ability of the individual to function in relationships, in family, in community, to gain and retain housing, education and employment, and to stay out of more intensive intervention services – broadly, to lead contributing lives in thriving communities.

While Peer to Peer programs such as GROW’s are low intensity and have low unit costs, they deal with people who have illnesses ranging from mild to moderate to severe episodic and severe and persistent. They help people keep well and in the community, on their medications and out of expensive acute services, supporting them in housing and to gain and retain employment – to achieve recovery in ways which they define.

Again, the value of the gain reflects the outcome for the consumer, and investment in peer groups is a low intensity, low cost and high value investment – with application across the complete spectrum of mental ill-health.

¹⁰ Commonwealth of Australia 2019,
[https://www1.health.gov.au/internet/main/publishing.nsf/Content/2126B045A8DA90FDCA257F6500018260/\\$File/1.%20PHN%20Guidance%20-%20Stepped%20Care%20-%202019.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/Content/2126B045A8DA90FDCA257F6500018260/$File/1.%20PHN%20Guidance%20-%20Stepped%20Care%20-%202019.pdf)

5. Student Peers also should be wellbeing leaders in schools

Draft Recommendation 17.3 discusses social and emotional learning programs in the education system while Draft Recommendation 17.5 proposes wellbeing leaders in schools.

GROW acknowledges the intent of the initiatives proposed for the education sector but considers there is a yawning gap because of the lack of identification of the importance of Peer to Peer Support programs among students. Currently there is a relative 'over representation' of the 'whole of school or class' approaches and the relative ease of delivering those programs (with very indirect outcomes) versus the more challenging approach of organised Peer to Peer Support for students identified as in need and the associated direct accountability/action/outcomes. GROW considers that the Commission should aim to rebalance investments in student health and wellbeing to provide for a significant increase in in-school Peer to Peer programs for students identified as at risk in recognition of the demonstrated value these programs bring.

Young people in the Mission Australia Youth Survey¹¹ reported that 83.0% of them will go to their friend/s for help with important issues in their lives. They have been consistently reporting their main issues of personal concern are coping with stress, school or study problems and mental health. Despite the best of intentions and significant investment in youth mental health programs, there has not been any discernible change in these results. This indicates that an expansion of existing programs is not sufficient. Addressing youth mental health requires new thinking and a new national approach.

The evidence from our schools-based Get Growing program and from other peer-based youth programs¹² shows that Peer Support programs can get students to come to school and to stay at school. Therefore, GROW recommends that the Commission's final report gives far greater emphasis to the role which students can play in schools in helping themselves and each other through Peer to Peer programs, rather than having things done to or for them – the first builds resilience and stronger community within schools, while the second puts them into a care and treatment pathway and exposes them to stigma and discrimination.

A care and treatment pathway may be important for some students, but the pathway as currently proposed is incomplete because it does not include the opportunity for students to support each other and through that support to aid their own resilience and coping skills, thus keeping them out of more intensive and potentially stigmatising services.

"It's a good course because being around other that who have similar issues or thoughts, makes a person know that they are not alone"
- Yr.8 student, Darwin Middle School, on Get Growing.

GROW welcomes the focus on the early years and the impact of issues such as childhood trauma on health and wellbeing throughout the life span. We also welcome the emphasis on schools and note that the Commission has identified leadership as "the missing piece of the puzzle" in the education system (Vol. 2, p685). The Commission's response is to propose the appointment of school wellbeing leaders. While these positions are not necessarily designated for teachers, the Commission notes:

"A teaching background is essential, however, in enabling the school wellbeing leader to support other school staff members in implementing wellbeing initiatives." (Vol. 2, p687).

¹¹ Carlisle E., Fildes, J., Hall, S., Perrrens, B., Perdriau, A., and Plummer, J. 2019, Youth Survey Report 2019, Sydney, NSW: Mission Australia. <https://www.missionaustralia.com.au/what-we-do/research-impact-policy-advocacy/youth-survey> Accessed 22 January 2020.

¹² Curtin University, Western Australian Centre for Health Promotion Research, My-Peer Toolkit. <http://mypeer.org.au/about/> Accessed 19 January 2020.

GROW contests this. GROW acknowledges there may be benefits in having a teaching background to facilitate support for and from other school teachers but our experience with our Get Growing schools-based program would query whether they are the right people to be “implementing wellbeing initiatives”. We also suggest the role described for wellbeing leaders (p687) is not complete because of that lack of identification of what students can and will do for each other when given a structured opportunity – a Peer to Peer Support approach. It is clear from the Mission Australia 2019 Youth Survey that young people do not see teachers or school counsellors as the people to approach for support or guidance.

Research¹³ shows that peer-based programs for young people:

- Offer a low level of threat as they are non-judgemental and strength based
- Provide learning opportunities through role modelling
- Empower participants to help themselves
- Help hard to reach target groups access support
- Are more acceptable to young people than mainstream support services
- Are cost effective.

One of the big added values identified by teachers, counsellors and funders of Get Growing is that our staff actually go into schools and deliver the program. Schools need community agencies to deliver services such as this into schools and, for all its value, the Australian Government funded program, Be You, does not do that.

Teachers and principals also appreciate the fact that Get Growing helps them meet their National Curriculum requirements in the area of Personal and Social Capability – Get Growing is in fact designed to build those capabilities over the course of the 10-week program.

There are 3 dimensions of the National Curriculum including 3 Cross Curriculum Priorities, 8 Learning Areas, and 7 General Capabilities. Get Growing meets the national curriculum standards by satisfying the Personal and Social capabilities which are part of the General Capabilities. The key elements for Personal and Social Capability are organised into four interrelated elements in the learning continuum, including; self management, self awareness, social management, and social awareness. Those elements are progressively built upon by the different modules in the 10-week course.

Our experience with Get Growing suggests the following:

- Teachers have an important role in education of students about health, and social and emotional wellbeing
- They also are well placed to identify students at risk (aided by school counsellors, parents, etc)
- If given the opportunity students are well placed to help each other, and by helping each other can help themselves through structured Peer to Peer approaches
- Teachers are not well placed to facilitate Peer to Peer programs because their education background teaches them how to take more of a command and control approach – to tell students what to do and what they need to be learning
- Student Peer Support needs to be undertaken in a non-judgmental, flexible way where the conversation goes wherever the students want it to go – not through an authoritarian approach
- In a true Peer to Peer approach, the teacher is not in control in the classroom: rather the students take over and work together to solve each other’s problems. A teacher or counsellor will be present

¹³ Ibid

but will not take part in the discussion between the students and hence the students are more likely to open up with each other and help each other problem solve

- Facilitation of these sessions is best undertaken by (younger) people trained as Youth Health Workers or Community Development Officers who are prepared to be flexible and “go with the flow”
- Therefore, even with Wellbeing Leaders, schools need to be funded to bring in these types of services rather than relying on visiting psychologists, doctors or others, or in referring out to headspaces or community mental health services.

Get Growing goes beyond just providing information or training staff, and provides an evidence based 10 week program in schools for students who have been identified as at risk by teachers, counsellors or parents. It helps them realise their personal value, that they are not alone in having problems, how to keep safe, how to support each other – again, building social inclusion and community within schools – and how to set goals and be resilient.

This is done in a non-stigmatising environment where students may otherwise not be attending school or where, if they were required to see a psychologist either in school, or be referred to one externally, they may not attend because of fear of discrimination.

FEEDBACK ON GET GROWING PROGRAM

What was your favourite part of Get Growing?

- “Not only getting help from my peers in the program but being able to help my peers and make them feel better.”

How did you grow through the past 10 weeks?

- “I’ve learnt to deal with my problems properly and how to differentiate my feelings from actual problems and issues. I’ve matured and understand my worth and how I can’t control every situation. Thank you for running this program and giving me this opportunity to be a part of it. It’s been a really good semester and I enjoyed it a lot.”

- Year 8 Palmerston College

A key finding of the roll-out of Get Growing to date has been the need to focus on younger students. The program initially was targeted at secondary school students aged 12-18. However, it was found that many of these students already had significant behavioural and mental ill-health problems. The program therefore has been extended to primary schools (so far, from Grade 5/age 10 and up).

“After being in this role for over a year, I have observed the positive impact that the Get Growing program has on our youth. This 10 week program allows the youth to take the time to recognise their self-worth and not only empower themselves but the other youth in the program. Get Growing really helps the youth to learn coping strategies, understand their feelings, and learn how to problem solve effectively. We teach them that their feelings are valid and their present circumstances do not define who they are nor what they can achieve in life. This program not only deals with the issues that are challenging for our youth, but it allows us to celebrate our differences and learn to value their unique self.” – Get Growing facilitator.

GROW uses the well-researched Strengths and Difficulties Questionnaire (SDQ) tool to measure the impact of Get Growing. Latest national results show that, among student participants:

- 60% saw an improvement in believing they are a valuable person
- 50% reported they worried less
- 45% of students said the program helped them to solve their problems
- 40% made improvements in their physical health, increased self-esteem, and learning how to solve problems in a helpful way
- 35% saw an improvement in talking to someone they trust if there is an issue
- 70% were able to recognise they were a valuable person.
- 50% recognised an improvement in how to manage their feelings.
- There was a 33% improvement in being able to see their own strengths, knowing a trustworthy person to talk to, and that bullying had decreased.
- Over 30% recognised that there was improvement in their self-esteem and pro-social peer relationships.

Financial support from Kinetic IT in the Northern Territory enabled Get Growing to be delivered to an additional three schools in Darwin in 2019, with the student self-evaluation (carried out at the start and the end of the program) highlighting the following results:

- 61.5% reduction in bullying
- 63% increase in helpful problem solving skills
- 50% increase in their physical health
- 35% increase in identifying personal strengths
- 75% increase in helping vulnerable peers
- 63% increase in self-esteem
- 25% reduction in self-harm

5.1 Value

These are high value, low cost programs:

- The 10 week course costs about \$4000 to aid 10-15 students at a time
- It brings students to school and helps them to stay at school
- It helps schools and teachers achieve the objectives in the National Curriculum by satisfying the Personal and Social capabilities requirements and in turn lessens the burden on principals, teachers and families.

6. System governance

GROW considers that both the renovate and rebuild options provide imperfect alternatives for systems governance. However, the rebuild model brings far greater risk without necessarily creating greater opportunity for significant gain.

In particular, if Regional Commissioning Authorities are just LHNs/LHDs/HHSs in disguise, that will be a backward step. These bodies are already conflicted because they operate as both funders and providers (unlike PHNs), hence we have seen no significant shift in funding patterns away from acute services (which LHNs fund and operate) to community based services which keep people out of hospital. We query whether this type of structural reform is worth pursuing. There is a risk it will become just another bureaucratic process. At best it will be a distraction, at worst it will be a waste of time and money.

In its draft report, the Commission expresses the view that it favours “State and Territory Governments having flexibility in how they construct their RCAs and, hence, do not wish to propose a prescriptive model” in relation to RCA governance. This rings alarm bells. The experience from National Health Reform, when LHNs were formed, was that states and territories were opposed to moving to regional commissioning bodies separate from their major hospital provider services. This is why there are 147 LHNs across Australia, with 85 of them in Victoria.

One of the pillars of *Contributing Lives, Thriving Communities* – the 2014 review by the National Mental Health Commission¹⁴ – was that it integrated mental health in the broader health and social services systems: it did not treat it as a separate silo, but rather emphasised that good mental health and social and emotional wellbeing are dependent on a holistic approach which also includes physical health and various social determinants of health – not on treating mental health as a silo.

In contrast, the Rebuild model in the PC draft sets mental health up as a silo which means it is someone else’s responsibility, when it should be everyone’s responsibility.

In addition, handing the funding and responsibility to the states appears to be a regressive approach in that jurisdictions are notorious for putting the welfare of their institutions ahead of the overall good of the community – in other words, funds are likely to be swallowed up in acute care in times of funding crises, and there will always be crises.

In these circumstances, GROW considers that it is vital for the Commonwealth to have strong financial leverage in policy, planning and commissioning to ensure overall strategy is focused on Commonwealth priorities such as prevention, early intervention, strengthened primary health care and recovery. It is clear from the Fifth National Mental Health and Suicide Prevention Plan that there is an absence of actions to address these very worthwhile objectives when implementation is left to the States.

Consumers and advocates have long argued for greater transparency over mental health funding.¹⁵ The challenge in most if not all jurisdictions is that budget allocations and expenditure on mental health programs are generally reported by the health departments as funds allocated to local health services. However, those health services are not required to report at the program level leaving no transparent readily accessible information in budget papers to give confidence that funds allocated to health services

¹⁴ NMHC (National Mental Health Commission) 2014 *Contributing Lives Thriving Communities Review*, <https://www.mentalhealthcommission.gov.au/monitoring-and-reporting/national-reports> (accessed 19 January 2020).

¹⁵ Rosen, Goldbloom, & McGeorge, 2010 *Mental Health Commissions: making the critical difference to the development and reform of mental health services* <https://www.ncbi.nlm.nih.gov/pubmed/20871404> Accessed 23 January 2020.

for mental health are actually spent on mental health. This is one of the challenges that the WA Mental Health Commission is seeking to address with specific agreements with each health district.

GROW applauds proposals for funds pooling and integrated commissioning of services around the needs of individuals, families and communities. But we consider this should be done through existing structures rather than going through another prolonged period of structural upheaval.

GROW therefore considers that PHNs should be given responsibilities for expanded commissioning roles while LHNs should be made more accountable for integration and coordination with PHNs, as well as for what they spend – and how they spend – on their mental health budgets. It is considered that the renovate model could be improved with the following variations:

- Increased accountability and public reporting on progress on co-commissioning by LHNs and PHNs
- Clear accountabilities for LHNs and PHNs to demonstrate engagement and participation with consumers, carers and other service providers in co-design, planning, commissioning, delivering services and monitoring and evaluating performance
- A services planning agenda which sets funding/percentage targets for increasing investment in prevention, early intervention and primary health care
- Targets for increasing funding to strengthen the role of the non-Government sector in prevention and early intervention, as well as in helping to cover the “missing middle”
- Targets for reducing the need for hospitalisation and ED presentations
- Consistent contractual arrangements across Australia from PHNs/LHNs: if there are to be multiple funders (and there always will be), the cost to service providers should be minimised by ensuring consistency in contracts, terms, and reporting, with consistent longer contract terms to provide greater certainty for organisations and their staff
- Reporting on high quality and comparable performance data for monitoring performance.

6.1 The role of Mental Health Commissions

GROW also seeks to comment on some aspects of the effectiveness of mental health commissions in advocating for consumers. We make no comment on the efficacy of giving the power of a statutory body to the NMHC except to note that both Queensland and New South Wales commissions are statutory bodies in contrast to Western Australia and South Australia. From a consumer perspective, there is no evidence that their support for the consumer voice is impacted by this statutory status. Any changes to governance must consider how it can leverage the positive developments that have evolved over recent years.

GROW has observed that the effectiveness of commissions, at the state or national level, lies in their capacity to influence decisions made by government. Three particular instances are of note, engagement across government, promotion of the consumer voice, and specific mechanisms to protect human rights.

- **Engagement across government:** there are clear examples from all state-based commissions of engagement with other government departments in addressing mental health and wellbeing.

An independent review of the work of the QLD MHC's work in relation to social housing, points specifically to its independence from Health as a contributing factor in the successful outcomes

for people with mental health issues in public housing¹⁶. The WA MHC provides resources about court diversion on its website¹⁷.

Consumer voice: Both the NMHC and the NSW MHC have specific roles for consumer commissioners. This is seen by consumers as an important signal that consumers' views are valued and support the concept of "nothing without us". Both Qld and WA also have strong consumer representation on advisory councils. System governance must continue to address the importance of consumer voices at the highest level.

Consumer rights, advocacy and human rights: The WA Mental Health Act 2014 has very strong provisions for the protection and promotion of consumer rights. Most of these provisions were introduced into the Bill after the MHC was assigned lead responsibility for the Act's review. Similarly, the Qld MHC made strong submissions to the government on the review of the legislation and many of those provisions are contained in the new Act. Its final submission¹⁸ identifies areas when consumer rights could be more strongly protected and points to differences across jurisdictions – see for instance comment on the well-regarded Victorian approach (P16). This submission also provides an overview of different approaches to the establishment and operation of the Mental Health Tribunals across Australia. These are an important mechanism in the protection of rights of people subject to involuntary treatment orders. These state-based processes are important elements of the broader mental health system with direct impact on consumers.

6.2 The WA Mental Health Commission

The WA Mental Health Commission (WA MHC) was launched in 2010 with policy, planning and purchasing powers to drive reform in mental health.¹⁹ Its functions included both state-wide policy and purchasing of services. It differs from other Mental Health Commissions subsequently established at the National level, in New South Wales, Queensland and South Australia whose functions are largely monitoring and policy advice although all have an across Government mandate to some extent.

There is evidence that the WA MHC has extended its reach beyond the traditional health system but its most significant purchase was and remains to fund the mental health services provided by the Department of Health using funds previously allocated directly by Government to that Department. Estimates Committee hearings from 2010 and 2019 show a continuing, albeit lessening, level of confusion among politicians about the responsibilities of each entity.

A report by the WA Auditor General in 2019²⁰ shows the complexity in identifying the package of services provided to individual patients as opposed to aggregate episodes of care, with three essentially separate service settings: mental health services provided in emergency departments which are not considered

¹⁶ KPMG (2017) Key Drivers for Policy and Practice Change in Social Housing <https://www.qmhc.qld.gov.au/documents/keydriversofpolicyandpracticechangeinsocialhousingfinalreport>. Accessed 22 January 2020

¹⁷ WA MHC. Court and police diversion resources. <https://www.mhc.wa.gov.au/reports-and-resources/resources/court-and-police-diversion-resources/>. Accessed 22 January 2020

¹⁸ QMHC (2015) Mental Health Legislation. Submission to the Health and Ambulance Services Committee of the Queensland Parliament. <https://www.qmhc.qld.gov.au/sites/default/files/wp-content/uploads/2015/06/Submission-to-Parliamentary-Committee-mental-health-legislation-October-2015.pdf>. Accessed 22 January 2020.

¹⁹ van Schoubroeck, L (2012). Western Australia's Mental Health Commission, *Mental Health Review Journal*, 17 (4) P229-237

²⁰ Auditor General, Western Australia (2019). An analysis of the Department of Health's Data Relating to State-Managed Adult Mental Health Services from 2013 to 2017. Report 9:2019-20 <https://audit.wa.gov.au/reports-and-publications/reports/mental-health-2/> Accessed 21 January 2020

specialist mental health care and not funded by the Commission, specialist mental health services delivered by the public health system and funded by the Commission, and non-government mental health services funded directly to community organisations by the Commission.

This demonstrates the challenges in tracking funding and levels of service provision when more than one agency is involved in the treatment of a person who may have both mental health issues and general health issues. In contrast, GROW understands that Queensland is increasingly moving to a model of regional commissioning to non-government organisations through the Hospital and Health Services.

Whichever model is adopted, any move to decentralisation must come with increased accountability. As evidenced in the Barrett Commission of Inquiry in Queensland, when accountability is sacrificed or unclear, the results in health can be devastating²¹. It should be noted that the WA MHC holds only state health department recurrent funding for mental health: it does not hold capital funds (and as the Commission has pointed out (p964), RCAs would not be properly positioned to hold capital for large hospital developments) and nor does it hold funds from other portfolios which are used to determine the mental health and wellbeing of the WA public (e.g. housing, education, justice).

7. Unused and under-used data

Draft recommendation 22.4 proposes establishing targets for outcomes, with accountability for mental health outcomes including measurement against predetermined performance targets.

Information Request 25.1 seeks further information about what specific datasets are being under-utilised, the reasons why specific datasets are being under-utilised including examples of existing barriers, and what potential solutions can be practicably implemented to improve use of specific datasets.

GROW agrees that a relentless focus on outcomes should drive selection of mental health performance indicators, and in turn that should drive what data are collected and analysed, with standard data collection systems, age groups and the likes. Too much of the current approach involves identification of what data is available which then drives what performance indicators can be measured rather than what outcomes need to be pursued – that needs to be reversed.

There continues to be a paucity of sufficient integrated data about the determinants of what creates good mental health and wellbeing. A disintegrated mental health system, as recognised in numerous reports and reviews (including the Draft Report) results in disintegrated data and therefore difficulty in providing a comprehensive picture, particularly in relation to the social determinants of what makes good mental health and wellbeing.

However, the reality is that there are significant amounts of data which are publicly available but unused (not analysed) or which can be extracted from existing data sets if the right questions are asked of the data custodians (and of course sometimes this involves additional costs). Yet while the data are available, much national reporting currently does not go into the level of granularity which is available through effective analysis and hence the magnitude of the impact and prevalence of behaviours, barriers and activities for particular age groups (e.g. children and young people) or specific at risk groups (e.g. LGBTIQ) can be masked and diluted by population-wide approaches.

To improve comparability and analysis of data (including over time), a consistent approach to data collection should be adopted, not just across all health jurisdictions but also across related portfolios

²¹ Wilson, The Hon Margaret QC (2016). Barrett Adolescent Centre Commission of Inquiry. <http://www.barrettinquiry.qld.gov.au/> Accessed 21 January 2020.

which impact on mental health and wellbeing e.g. education, employment, housing, justice and social services.

When detailed analysis is undertaken of existing (but often unreported or unanalysed) data, the indicators overwhelmingly demonstrate the rise of mental ill-health among children and young people, particularly in the age range 15-24. In some instances, proportions and rates are higher among those 25-34: after that, proportions and rates tend to reduce by age.

Therefore at a minimum, that consistent approach should cover age ranges across the lifespan (0-4; 5-11; 12-17; 18-24; 25-34; 35-44; 45-54; 55-64; 65-74; 75-85; 85+) (generally AIHW and ABS already can do this but it is not always publicly reported in this way, and mental health monitoring reports for some reason do not go to this level of detail, even though it is highly valuable).

It should also cover:

- Sex
- Indigenous status
- Socio-economic disadvantage
- Geographic location.

Draft Recommendation 25.2 proposes routine national surveys of mental health and GROW agrees.

Ideally, the proposed Intergenerational Health and Mental Health Study should be designed in such a way that it collects data for every single age with sufficient sample size (where possible) to be able to access and report the data disaggregated by sex, state/territory/remoteness/SEIFA/ATSI, and other vulnerable populations. In this way, parties whose interests lie in particular age ranges or with particular population groups can access the data accordingly, as well as being able to align with the age ranges identified above. The richness of this data for planning and decision-making purposes will be worth the investment over the longer term.

The Study and other surveys should look to bridge the data divide for the 4-15 year old population which is relatively underserved in national surveys compared with 15 plus, who are more broadly serviced by the Australian Bureau of Statistics (ABS).

Targets should be set so that public reporting can occur which indicates whether progress is being made in achievement of goals for improvements in mental health and wellbeing. While indicators can aid in identifying where, when and how things change or are different, targets show what direction things should be going in, aid in identifying what impact is being made and how quickly desirable changes are occurring. They need to be specific, measurable, and enable public accountability.

In addition, data tables from publicly funded surveys should be made readily available to the public and to research institutes and individuals to enable more detailed analysis of findings.

Data collecting and reporting in new surveys should compare people with and without mental health conditions. Reporting against national mental health performance indicators by the National Mental Health Commission also should compare data for people with and without a mental health conditions, wherever possible. While this information often can be obtained, it is not being used as effectively and as often as it could be. A report published by the Queensland Mental Health Commission²² demonstrates

²² QMHC (Queensland Mental Health Commission) (2016). Performance Indicators Report 2016.
<https://www.qmhc.qld.gov.au/about/publications/browse/indicator-reports/performance-indicators-report-2016>. Accessed 20 January 2020.

that there is a significant amount of data available but national leadership is required to ensure it is current, comprehensive and used.

Data collection and analysis should compare how well all mental health contacts with health services – community mental health, emergency departments, outpatient and inpatient services – match the prevalence rates of mental ill-health, to determine whether differences in ages and sex in the prevalence of disorders matches the patterns of health service contacts.

Opportunities should be examined for improvements in alignment of data collections on psychological distress, with universal age stratification and consistency in what is collected/reported: high, very high AND high/very high (combination of both). This should include examination of the impact of using different versions of the K10 assessment tool e.g. the K5 for Aboriginal and Torres Strait Islander peoples in the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS).

In monitoring and reporting on the Fifth National Mental Health and Suicide Prevention Plan, the NMHC should report on children and young people where that data already are available – the first Performance Report against the Fifth Plan did not do this. For example, with Performance Indicator 24 – Experience of discrimination in adults with mental illness – the latest NMHC Progress Report Data includes one age group: people aged 18 years and older. Yet the survey this is based on covers Australians aged 15 years and over, with data breakdowns available for age groups, sex, remoteness, socioeconomic status, Indigenous status and state and territory. Data is available on the age range 15-24 and in future this should be included rather than having those aged 15-17 excluded from the results (especially when it is not possible to disaggregate separately into 15-17 years). The snapshot provided by the NMHC covers such a broad age range that the outcome is of limited value, yet this was totally avoidable.

A specific design focus of survey work should be on at risk, vulnerable and other populations, with survey design undertaken to ensure sufficient representation to provide meaningful results e.g. CALD communities; Homeless; LGBTIQ; refugees; young people in the justice system; those with dual diagnosis (e.g. alcohol and other drug dependencies) and other disabilities.

Data are available for Aboriginal and Torres Strait Islander peoples for 2014-15 from the National Aboriginal and Torres Strait Islander Social Survey (NATSISS). The next data available for Indigenous Australians will be in December when the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) 2018-19 is being released. It should be noted that, between the two surveys, the information on mental illness is collected using different methodologies, so the time points cannot be easily compared with each other. This is unfortunate and is something that future survey design should aim to avoid.

Indicators are required which pick up the missing middle in mental health – the gap between what GPs and primary health care do on the one hand, and what specialised community mental health services, outpatients and Emergency Departments do on the other. This should include the impact of the missing middle in terms of ages groups, recognising the large spike in mental health-related ED presentations occurring in the age ranges 12-17 and 18-24, as well as in the age range of 25-34. This data should be used to answer the question as to whether presentation to an ED was the most appropriate way of accessing mental health services for children and young people, or whether services could have been accessed which could have prevented an emergency.

Targeted research is required on the impact of, and equity of access to, Mental Health Treatment Plans (MHTPs) and the Better Access program. There are significant variations in access to MHTPs between states and territories: however, there is little information on what impact those differences make on the health and wellbeing of individuals, families and communities.

A standardised approach should be mandated for surveying techniques and age ranges across Australia for the Your Experience of Service (YES) survey, as a quality measure of engaging consumers in a feedback process, so they can identify issues and influence improvements in care and support. State and territory governments should offer the YES survey to consumers during every hospital stay or community health centre visit across Australia. The survey has been extended beyond the public sector and adapted for use by Non-Government Organisations (NGOs), as well as for Primary Health Networks (PHNs). Organisations should be encouraged to undertake these surveys and publish their findings. It also is recommended that the YES survey be used/adapted for use in the private sector to enable a more comprehensive and cohesive picture of the experience of consumers receiving mental health care across the system.

A consistent approach should be taken in public reporting when using rates and proportions. Currently the terms are often used interchangeably yet they are different things. Rates generally measure the frequency/occurrence of an event within a defined population over a specific period of time typically as a rate per population, while proportions generally measure the number/counts in the numerator compared with those in the denominator, typically as a percentage. Reporting both rates and proportions is recommended where these data are available.

Likewise, there is a difference between activity such as service contacts on the one hand and individuals on the other, but at times they are used interchangeably. An individual may have two or indeed many more service contacts within the one data set – indeed when dealing with high variations between small samples it often can be as a result of numerous service contacts for a small number of people. Specifying whether data are being reported on the basis of activity such as service contacts or individuals would assist in analysing data correctly. Additionally, being able to report data by both activity such as service contacts and individuals would add further depth for data analysis.

Indicators themselves, in their descriptions, should include the desired outcome including decreases or increases in the occurrence of what is being measured (e.g. rates of suicide).

Other findings and recommendations

In this section, Grow has chosen to only respond to those recommendations and findings where:

- (a) They have a direct impact on the services which Grow provides to clients; and/or
- (b) There are ways in which Grow considers those recommendations could be improved.

INFORMATION REQUEST 5.1 — LOW-INTENSITY THERAPY COACHES AS AN ALTERNATIVE TO PSYCHOLOGICAL THERAPISTS

We are seeking information on the gains from having a greater share of treatment provided by low intensity therapy coaches. This includes:

- *improvements in mental health outcomes and/or the cost effectiveness of therapy for consumers and the wider community*
- *the groups of consumers that would most benefit.*

COMMENT:

Again, Peer Support or Peer to Peer group work (including on-line) should be included in these considerations, given the demonstrated cost effective nature of these services.

Low intensity therapy coaches have a role as a member of a treatment team: their role is to do something for or to someone with a living experience: this is a peer work role. On the other hand, enabling someone with a living experience to become a part of a peer group is a mutual support, bi-directional relationship which builds community for those participants.

GROW's group programs, including training, cost about \$1,000 a month – depending on the number of participants – which is very cost effective when compared, for example, to costs of hospitalisation or ED attendances. The costs are higher for groups conducted in corrections services because each meeting needs to be facilitated, and in some other settings.

DRAFT RECOMMENDATION 8.1 — IMPROVE EMERGENCY MENTAL HEALTH SERVICE EXPERIENCES

In the short term (in the next 2 years)

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.

COMMENT:

Agreed. Intentional Peer Support provides a very cost effective alternative to attendance at an ED.

Such services need to be set up separate to the hospital ED e.g. in Safe Haven Cafes.

DRAFT RECOMMENDATION 11.4 — STRENGTHEN THE PEER WORKFORCE

COMMENT:

Supported. However, a similar recommendation is required on how to strengthen Intentional Peer Support so that all people who want and need such a Peer to Peer service get the opportunity to access such a service.

DRAFT RECOMMENDATION 10.2 — ONLINE NAVIGATION PLATFORMS TO SUPPORT REFERRAL PATHWAYS

Access to these platforms should be expanded beyond health, in particular to schools and psychosocial service providers.

COMMENT:

Surely the referral pathways should include psychosocial service providers, as well as Intentional Peer Support? It should not be about them being given access but rather they are a part of the pathways and hence would automatically be included in the platforms?

DRAFT RECOMMENDATION 10.3 — SINGLE CARE PLANS FOR SOME CONSUMERS

Governments should support the development of single care plans for consumers with moderate to severe mental illness who are receiving services across multiple clinical providers.

COMMENT:

This should go beyond clinical providers to include all those providing a service, including NGOs and Peer Support.

Noting that not all individuals identified with moderate to severe mental illness will want a single care plan, this should be a matter of choice and participation.

The same point applies to care coordination services (Draft Recommendation 10.4).

DRAFT RECOMMENDATION 12.1 — EXTEND THE CONTRACT LENGTH FOR PSYCHOSOCIAL SUPPORTS

COMMENT:

Agreed. This should go further to seek cross-government commitment to standard contracts, terms of contracts, and reporting requirements so as to reduce the red tape burden on service providers.

Carers and families REFORM OBJECTIVE: Increased support for the wellbeing and role of carers and families of people with mental illness

COMMENT:

GROW notes that this section does not identify the role of Peer Support for carers which can be a vital aid to enable them to perform their roles.

GROW was funded by the Australian Department of Social Services to conduct Peer Support groups for carers in the Gippsland area of Victoria. That funding expires at the end of May 2020 but the need continues – particularly in the face of the recent bushfires.

GROW has found this program to be highly popular among carers who are able to share their experiences, learn from each other and support each other.

Grow has identified the rural and remote regions within Victoria as an area of high need for support programs for Carers and consumers of mental health programs. Grow continues to invest in providing peer support groups, both face to face and online, utilising video conferencing platforms which enables greater accessibility for isolated communities and carers.

Grow also has responded to carer needs by providing much needed ongoing psycho-educational workshops which also provide opportunity for building social networks between carers within such regions. Being able to provide carer support in the form of peer support groups mitigates in some part the isolation felt by many within the more remote regions.

Providing mental wellness groups for carers has proven extremely successful as has being able to assist new carers with one on one support to navigate the pathways to other supports such as counselling and access to the NDIS, respite services for the carer and other specialised services.

It is further noted that Part 17 of the WA Mental Health Act 2014²³ includes specific provisions on the recognition of rights of carers and families. GROW understands it was hard fought by WA Carer groups when the legislation was developed in 2012-13, in particular parents who felt they were ignored by treating teams. System reform requires not only policy but implementation in the form of funded services to ensure positive change in people's lives.

DRAFT RECOMMENDATION 16.3 — MENTAL HEALTHCARE IN CORRECTIONAL FACILITIES AND ON RELEASE

Mental health screening and assessment of individuals in correctional facilities should be undertaken to inform resourcing, care and planning for release.

COMMENT:

²³ See the Act at:

[https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_40843.pdf/\\$FILE/Mental%20Health%20Act%2014%20-%20%5B01-f0-03%5D.pdf?OpenElement](https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_40843.pdf/$FILE/Mental%20Health%20Act%2014%20-%20%5B01-f0-03%5D.pdf?OpenElement)

GROW recommends that this be extended to youth aged 10-17 under youth justice supervision in Australia.

The absence of national-level data regarding the health of young people aged 10-17 in the justice system is a significant gap in available information. In contrast, there is a national-level data collection and indicator set for the adult prisoner population. Therefore, there is an opportunity and indeed an imperative to develop a regular survey (census) specifically for young people under youth justice supervision. This could be informed by existing surveys such as the 2015 Young People in Custody Health Survey, NSW.

INFORMATION REQUEST 16.1 — TRANSITION SUPPORT FOR THOSE WITH MENTAL ILLNESS RELEASED FROM CORRECTIONAL FACILITIES

We are seeking further information on transition support for individuals with mental illness released from correctional facilities (on parole or not) that link them to relevant community services. This includes information on the benefits of transition support and the extent of transition support that should be provided.

COMMENT:

GROW provides a recovery focused mental health peer support program for people living in correctional facilities in Victoria. These groups are attended by both long-term prisoners and those who are transitioning out of these facilities and into the broader community. The program is facilitated by GROW staff with decades of experience in correctional settings.

The program does not duplicate existing service delivery. There is no other continuous mental health peer support service that would operate in maximum, medium, minimum, remand, post-transitional and general community in Australia, or as research suggests – internationally. The proposed program complements existing mental health supports in correctional and post-correctional settings. GROW's national annual survey shows that participants improve their use of and ultimately reduce their dependency on clinical mental health services. Participants improve their understanding and navigation of mental illness, treatments and services. In addition, participants enhance their social inclusion and economic participation.

Mental illness is three to five times more prevalent among prisoners than in the general community. Just over 25 per cent of newly remanded prisoners have a mental illness, with the prevalence of schizophrenia or bipolar disorder almost ten times greater than the general population and the prevalence of depression at least 50 per cent higher than the general population.²⁴

The GROW program provides community-based continuous mental health peer support for people living in correctional facilities as they move out of these facilities and into the broader community. Implementing the Grow program provides the missing link between existing Grow mental health support groups in maximum and medium security correctional facilities and

²⁴ Because mental health matters: Victorian Mental Health Reform Strategy 2009-2019, Victorian Government, 2009.

general community Grow groups. The program complements existing mental health supports in correctional and post-correctional settings.

DRAFT FINDING 20.1 — SOCIAL EXCLUSION IS ASSOCIATED WITH POOR MENTAL HEALTH

Social exclusion is strongly associated with poor mental health. People with mental illness are more likely to be socially excluded, and people facing social exclusion for other reasons are likely to subsequently experience poor mental health.

People likely to experience both social exclusion and poor mental health include those on lower incomes and with poor access to material resources, single parents, Aboriginal and Torres Strait Islander people, people who live in public rental accommodation, and people who do not complete secondary school.

COMMENT:

Strongly agreed noting this is the foundation of the formation and ongoing development of GROW and its services.

GROW has helped tens of thousands of people to overcome social exclusion through its Peer to Peer support programs.
