Consumer Perspective, Lived Experience Expertise Peer Operated Services Multi- disciplinary Teams Climate Emergency Prevention

Trauma and Healing Focus

Not ‘mental illness’ and lack of hope.

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Northern Rivers is a hothouse example of everywhere else in NSW/Australia

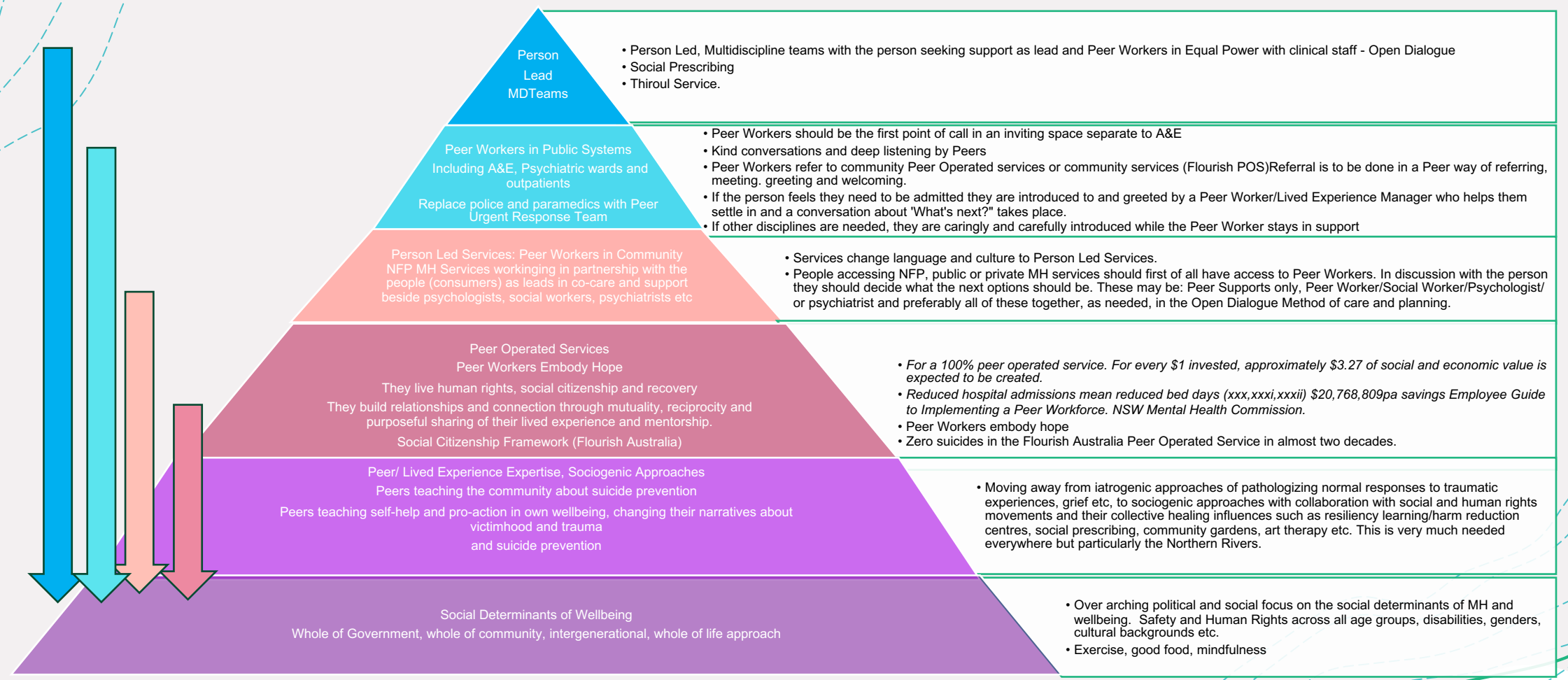
- Covid- isolation, loneliness, changed relationships, poor social skills.
- Massive impact from climate change, fires and floods – young people losing hope.
- We experienced Armageddon and our eyes cannot unsee what we experienced. Our suicide rate is now the highest in Australia.
- Aboriginal Communities
- Higher percentage of kids in out of home care
- Not enough medical, aged care, disability services,. Drop in bulk billing
- Poor public transport: Isolation, loneliness, poor health outcomes
- Decline of the fabric of society – Self medicating, unemployment, anti-establishment, anti-vax etc.
- Homelessness not only of the local people- people from across Australia
- Very rich and very poor- Poor people desperate & rebelling. Jails being filled because social determinants of wellbeing and MH services aren't available.
- Disrespect for authority because authority is letting the people, climate and nature down – police, politicians (local, state, federal), MH services, paramedics, Centrelink (Robo Debt Trauma and deaths)
- Listen to what we need, create it and then roll it out across NSW and Australia.

We must treat trauma! The basis of most MH issues

- Where are the services that support and treat trauma rather than cause it?
  - 52% of women who have experienced domestic violence will be given a diagnosis of mental illness after the DV. and 84% will get that diagnosis after the domestic violence. Abused boys grow up to be sociopathic and women grow up to be empaths.
  - Financial disincentives to GPs to support people in psychological distress especially women experiencing DV. Return vets are respected for their PTSD; Why not women?
  - Illawarra Women's Trauma Recovery Centre- Private funding- Must have public funding.
  - Peer Operated Services needed here because everyone has experienced trauma
- Studies of public mental health consumers have found that between 48 and 98 percent of clients reported a history of at least one traumatic event (4–6).

Trauma History Screening in a Community Mental Health Center Psychiatric Services https://ps.psychiatryonline.org › appi.ps.55.2.157

Pyramid of care, hope, healing and looping back round



- Person Led, Multidiscipline teams with the person seeking support as lead and Peer Workers in Equal Power with clinical staff - Open Dialogue
- Social Prescribing
- Thiroul Service.

- Peer Workers should be the first point of call in an inviting space separate to A&E
- Kind conversations and deep listening by Peers
- Peer Workers refer to community Peer Operated services or community services (Flourish POS)Referral is to be done in a Peer way of referring, meeting. greeting and welcoming.
- If the person feels they need to be admitted they are introduced to and greeted by a Peer Worker/Lived Experience Manager who helps them settle in and a conversation about 'What's next?" takes place.
- If other disciplines are needed, they are caringly and carefully introduced while the Peer Worker stays in support

- Services change language and culture to Person Led Services.
- People accessing NFP, public or private MH services should first of all have access to Peer Workers. In discussion with the person they should decide what the next options should be. These may be: Peer Supports only, Peer Worker/Social Worker/Psychologist/ or psychiatrist and preferably all of these together, as needed, in the Open Dialogue Method of care and planning.

- *For a 100% peer operated service. For every $1 invested, approximately $3.27 of social and economic value is expected to be created.*
- *Reduced hospital admissions mean reduced bed days (xxx,xxxi,xxxii) $20,768,809pa savings Employee Guide to Implementing a Peer Workforce. NSW Mental Health Commission.*
- Peer Workers embody hope
- Zero suicides in the Flourish Australia Peer Operated Service in almost two decades.

- Moving away from iatrogenic approaches of pathologizing normal responses to traumatic experiences, grief etc, to sociogenic approaches with collaboration with social and human rights movements and their collective healing influences such as resiliency learning/harm reduction centres, social prescribing, community gardens, art therapy etc. This is very much needed everywhere but particularly the Northern Rivers.

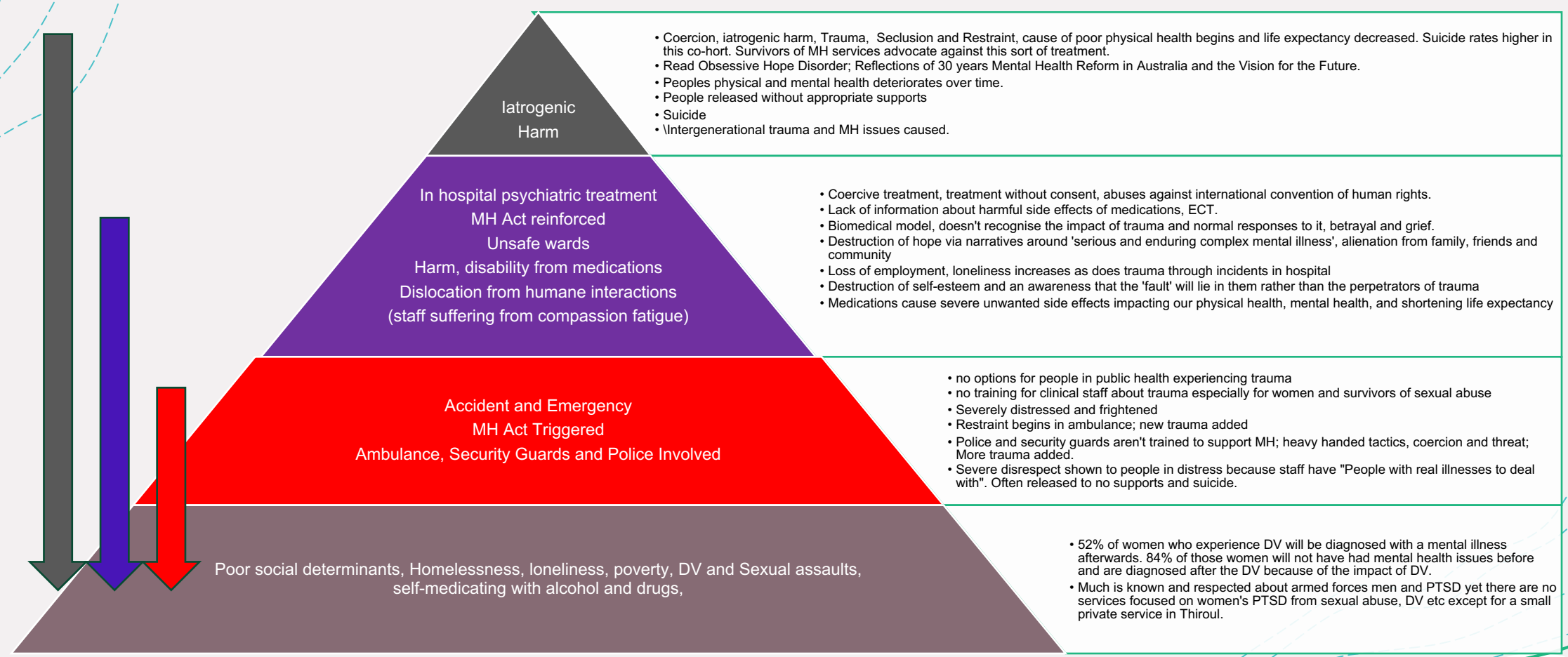
- Over arching political and social focus on the social determinants of MH and wellbeing. Safety and Human Rights across all age groups, disabilities, genders, cultural backgrounds etc.
- Exercise, good food, mindfulness

Evidence about Peer Support can't be denied

+ Shorter hospital stays (Lawn et al 2008, Nelson et al 2006, Forchuk, 2002, Trainor et al 1997, Trainor & Tremblay 1992)
+ Fewer hospital stays (CMHA 2005, Forchuk 2002, Chinman et al 2001, Trainor & Tremblay 1992)
+ Longer time in the community without hospitalisation. (Min et al 2007, Rebeiro et al 2001, Clarke et al 2000)
+ Reduced utilisation of crisis services (Lawn et al 2008, CMHA. 2005, Trainor et al 1997, Trainor & Tremblay 1992)
+ Reduced utilisation of psychiatrists, outpatient services, community mental health programmes, psychiatric medication, emergency department, GPs. (Nelson et al 2006, CMHA 2005)

Broken systems, lack of appropriate, timely supports, iatrogenic harm

Productivity Review



- Coercion, iatrogenic harm, Trauma, Seclusion and Restraint, cause of poor physical health begins and life expectancy decreased. Suicide rates higher in this co-hort. Survivors of MH services advocate against this sort of treatment.
- Read Obsessive Hope Disorder; Reflections of 30 years Mental Health Reform in Australia and the Vision for the Future.
- Peoples physical and mental health deteriorates over time.
- People released without appropriate supports
- Suicide
- \Intergenerational trauma and MH issues caused.

- Coercive treatment, treatment without consent, abuses against international convention of human rights.
- Lack of information about harmful side effects of medications, ECT.
- Biomedical model, doesn't recognise the impact of trauma and normal responses to it, betrayal and grief.
- Destruction of hope via narratives around 'serious and enduring complex mental illness', alienation from family, friends and community
- Loss of employment, loneliness increases as does trauma through incidents in hospital
- Destruction of self-esteem and an awareness that the 'fault' will lie in them rather than the perpetrators of trauma
- Medications cause severe unwanted side effects impacting our physical health, mental health, and shortening life expectancy

- no options for people in public health experiencing trauma
- no training for clinical staff about trauma especially for women and survivors of sexual abuse
- Severely distressed and frightened
- Restraint begins in ambulance; new trauma added
- Police and security guards aren't trained to support MH; heavy handed tactics, coercion and threat; More trauma added.
- Severe disrespect shown to people in distress because staff have "People with real illnesses to deal with". Often released to no supports and suicide.

- 52% of women who experience DV will be diagnosed with a mental illness afterwards. 84% of those women will not have had mental health issues before and are diagnosed after the DV because of the impact of DV.
- Much is known and respected about armed forces men and PTSD yet there are no services focused on women's PTSD from sexual abuse, DV etc except for a small private service in Thiroul.

Key recommendations

From detailed analysis described above, Mental Health Australia and KPMG have developed the following three recommendations and ten sub-recommendations:

Recommendation 1: Support individuals with mental health issues to gain and maintain employment, and maintain the mental health and wellbeing of the workforce

1.1 Workplace mental health interventions

Work with employers to improve workplace mental health and wellbeing

$4.5 billion in savings

1.2 WorkCover incentive trial

Trial adjustments to Workers' Compensation insurance premiums according to workplaces' mental health risk profile

$500 million in savings

1.3 Peer workforce trial

Trial a paid peer workforce to build the evidence base

Savings not estimable

1.4 Supported employment for people with a severe mental illness

Provide supports to people with a severe mental illness to gain and maintain employment

$120 million over two years

Recommendation 2: Minimise avoidable emergency department presentations and hospitalisations

2.1 Housing First for 15 - 24 year olds

Adopt a Housing First model for young people aged 15 to 24 with a mental illness at risk of homelessness

$1.6 billion in short term savings, $4.8 billion in long-term savings

2.2 Assertive outreach post-suicide attempt

Provide community-based assertive outreach to people who have attempted suicide

$100 million in short term savings, $1.0 billion in long-term savings

2.3 National minimum data set for primary mental health

Measure the impact of primary care on the use of secondary care by linking the new Primary Mental Health Care Minimum Data Set to wider health and social data sets

Savings not estimable

Recommendation: 3 Invest in promotion, prevention and early intervention

3.1 Early interventions in physical health

Provide community-based collaborative care to people with co-morbid physical and mental illnesses

$1.8 billion in savings

3.2 Prevention and early intervention

Invest in prevention and early intervention, and build the evidence base for promotion

$90 million in the short term

3.3 e-Health early interventions

Use e-health as an enabler to deliver early intervention services

$442 million in savings

In total, these recommendations would generate between $8.2 billion and $12.7 billion from an investment of under $4.4 billion. Wider health-related quality of life measures such as Quality

+ *Peer Work Hub, NSW MH Commission*
+ *Health NSW Gov. Website*
+ *KPMG and Mental Health Australia, Investing to Save, The Economic Benefits for Australia for MH Reform. Final Report, May*

Peer Work: Return on Investment

For a 100% peer operated service; every $1 invested, approximately $3.27 of social and economic value is expected to be created. Reduced hospital admissions mean reduced bed days yields $20,768,809pa savings

If a LE (Peer) supported hospital discharge program had the potential to reduce bed days by a conservative 5%. The cost of mental health bed day is $1,618. There was 256,722 patient days in 2020-2021.
Employee Guide to Implementing a Peer Workforce. NSW Mental Health Commission.
Improved model for Peer –STOC services would see an even greater return on investment and outcomes for people.

Ki Wi Way

A 3.5% increase in system capacity at a 0.2% increase in system costs

Question:

- If Peer Workers were causing people to have dangerous weight gain, diabetes, heart disease, dystonia, tardive dyskinesia, disability, thyroid, kidney and liver dysfunction, contribute directly to early deaths (15-27 years), locking people up against their wills, injecting and forcing people to take medications they do not want to take. Abusing their human rights; destroying their self-confidence. Giving them an alienating and socially debilitating diagnosis. Would Peer Workers still be employed?
- Yet these are the things that our MH Act allows clinicians, in partnership with pharmaceutical companies to do this every day to hundreds of people.
- We must change services and Peer Services are the way forward;

Must have funding for services for people NOT on NDIS!!

- NFP MH services struggling severely under the strain of MH Funding- must have more funding or more services will close
- NDIS is a good fit for physical disabilities but not working for MH
- Services must be readily available in the community and staffed by Peers with back up from clinical services, human services etc. if needed.
- Activity Based Funding also very dangerous in MH. – increased severity of diagnosis. (a whole other discussion).

Peer Urgent Response Teams

+ Replace paramedics and police with Peer Urgent Response Teams
+ Peer urgent Response Team or hospital setting Peer Connect Team can divert people from hospital and connect them to Peer Operated Services in the community
+ Online/on phone Peer Urgent Response Team replacing calls to lifeline teaching people how to manage their suicidal thoughts ad feelings
+ Peers teaching people to be proactive in their own care and suicide prevention.

Other evidence of reduced service utilization when people are supported by Peer Workers

+ Forchuk et al (2005) found service users who received peer support were discharged from hospital an average of 116 days earlier per person

+ Lawn et al (2008) evaluated an Australian mental health peer support service, which provided hospital avoidance and early discharge support. In the first 3 months of operation over 300 bed days were saved. Also found peer support has potential for encouraging a greater focus on recovery in both the culture and practice of mental health services.

+ Chinman et al (2001) compared a peer support outpatient program in the USA with traditional care and found a 50% reduction in re-hospitalisations compared to the general outpatient population. Only 15% of the outpatients with peer support were re-hospitalised in its first year of operation.

+ Min et al (2007) studied a peer support program over a 3-year period. Found participants receiving peer support had longer periods of living in the community without re-hospitalisations than a comparison group. 73% of people in the comparison group were re-hospitalised versus 62% in the peer support group.

Cited in Basset et al (2010) *Lived Experience Leading the Way.* UK.

Conclusion:

We need: Peer Operated Services
Peer Workers in all services;
Peer Urgent Response Teams

What we need in the Northern Rivers
We need across NSW and Australia

Thank you

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