Submission No 49

INQUIRY INTO EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES

Organisation: Flourish Australia

Date Received: 7 September 2023

Submission to the NSW Legislative Council:

Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

6 September 2023

flourish AUSTRALIA
Where mental wellbeing thrives

Our Vision

Creating communities where everyone's mental health and wellbeing flourishes.

Our Purpose

Supporting people to flourish, believing in their future and their place in the community.

Our Values

trust, respect, hope, inclusion, integrity, diversity and partnership.

Who we are

Flourish Australia[1] is one of Flourish Australia's largest specialist mental health service providers. Founded in 1955 in Sydney, NSW we have grown to deliver community based supports across metropolitan, regional and rural NSW, as well as South East Queensland, Melbourne, Canberra and Adelaide. Our team of 900 staff support just under 10,000 people with lived experience of mental health issues and psychosocial disability annually, through a range of social and emotional wellbeing, psychosocial supports and clinical supports. 56% of our team tell us they have a lived experience of a mental health issue. This includes close to 200 mental health peer workers. Our trauma informed, recovery-oriented, person-led services help people find and make a home, get a job, and meet people and learn new things. They also support families and carers to do their important work assisting family members on their recovery journeys.

We are a registered NDIS Service Provider.

[1] RichmondPRA Limited ABN 66 001 280 628

1. Background

Flourish Australia welcomes the opportunity to provide a submission to the Inquiry.

We have been delivering community based supports to people with complex mental health issues since the early 1950s. It was at this time that family members and community members gathered together to provide a social event at Callan Park Hospital. This developed into a gathering known as the Psychiatric After Care Club, an important part of which was a social dance each week within the grounds of the hospital.

Formalising the work of the volunteers who undertook this work, Psychiatric Rehabilitation Association was founded in 1955. The focus of the organisation was supporting people to move out of hospital and into the community.

Our quick timeline summarises where we have come from.

1954 – Callan Park (Rozelle) Hospital - Approval for weekly group sessions for patients facing discharge, named the Psychiatric After Care Club (PACC). First run by Richard Hauser, and later John Kingsmill.
1955 – Psychiatric Rehabilitation Association established. Hephzibah Hauser became Chairperson, Richard Hauser, Secretary, and John Kingsmill, Deputy Chair. Dr John Parkinson was also a founder. Established to promote "the formation of a hostel for male ex-patients, a club, an advisory centre, and a sheltered workshop".
1957 – The City Club - Movement of people out of hospital and into the community. Social dance at Winn's Department Store, Oxford Street, Darlinghurst.
1959 – Employment opportunities focus – Rozelle and Camperdown.
1970 – Richmond Fellowship of NSW established by Peter Bartok. Established to provide community-level rehabilitative support and transition to community life through supported housing accommodation operating as "therapeutic communities".
2012 – Merger of PRA and Richmond Fellowship of NSW to become RichmondPRA.
2016 – Name change to Flourish Australia.

You will note that in 2012 Psychiatric Rehabilitation Australia (earlier renamed from the Association) merged with another leading mental health organization, Richmond Fellowship of NSW to form RichmondPRA, which was renamed Flourish Australia in 2016.

We have been working in partnership with clinical mental health services and the Ministry of Health and Local Health Districts, in their many iterations, over the last 70 years.

In more recent years we have delivered a small number of clinical services, first as a Lead Agency headspace Centres – Bankstown, Broken Hill, Parramatta and Castle Hill, and more recently in the HASI Plus Program and an innovative Primary Care Psychiatry Liaison Services which sees us employ a party -time psychiatrist.

We have been involved as a NDIS service provider since the trial site commenced in the Hunter in 2013.

We have deep and long experience in providing successful psychosocial supports that have seen people with complex mental health issues transform their lives through trauma informed, recovery-oriented, person-led psychosocial supports. This is consistent with the National Framework for Recovery Oriented Services, National Standards for Mental Health Services, the recently released National Safety and Quality Mental Health Standards for Community Managed Organisations and the NDIS Psychosocial Recovery-Oriented Framework.

We are accredited or verified against a wide range of Service Standards including:

1. NDIS Practice Standards
2. National Standards for Disability Services
3. National Standards for Mental Health Services
4. Australian Service Excellence Standards
5. Aged Care Quality Standards
6. ISO 9001 Quality Management Systems
7. ISO 45001 Environmental Management Systems
8. ISO 14001 Work Health and Safety Systems

2. Members Organisations

We are a member of the Mental Health Co-ordinating Council, Mental Health Australia and the Australia Psychosocial Alliance (APA), amongst other representative organisations.

Notably, our founding organisations Psychiatric Rehabilitation Australia (PRA) and Richmond Fellowship of NSW were two of 8 founding members of the Mental Health Co-ordinating Council in 1983.

3. Terms of Reference

We offer the following comments in relation to the Committee's Terms of Reference.

We have taken to Committee's interest to be community mental health supports in the broadest definition. This includes community supports provided by public mental health services such as through Mental Health Teams, as well as community based supports provided by community managed organisations such as Flourish Australia.

In this submission we use the term "lived experience" to refer to someone's personal lived experience of a mental health issue, a person that, is in some contexts, referred to as a "consumer" of mental health services. That does not seek to diminish the lived experience of family and carers.

(a) equity of access to outpatient mental health services

Maximising people's health outcomes relies on access to health services. But we know that access to health services is unequal and can be impacted by a number of factors.

In discussing health equity, the World Health Organisation comments:

> "Equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental human right. **Health equity is achieved when everyone can attain their full potential for health and well-being.**
>
> Health and health equity are determined by the conditions in which people are born, grow, live, work, play and age, as well as biological determinants. Structural determinants (political, legal, and economic) with social norms and institutional processes shape the distribution of power and resources determined by the conditions in which people are born, grow, live, work, play and age.
>
> People's living conditions are often made worse by discrimination, stereotyping, and prejudice based on sex, gender, age, race, ethnicity, or disability, among other

factors. Discriminatory practices are often embedded in institutional and systems processes, leading to groups being under-represented in decision-making at all levels or underserved."[2]

In considering these comments, and as noted below, it is clear that there is not equity of access to outpatient mental health services in NSW. Equity of access would guarantee the availability of outpatient mental health services no matter where you live in the State. Of course, this comment must be tempered with a realistic understanding of what services are physically possible to deliver in some particularly remote places, and can be somewhat based on assumptions of availability of workforce and accessibility of technology and connectivity.

Equity of access also must consider specific needs of particular segments of the community, which is touched on notably in terms of reference (c) and (h), below.

Possible changes:
Equity of access could be improved by using:

- More co-production in community mental heath service and support models development
- Providing more alternatives to clinical/acute services
- Funding innovative approaches to community based services
- Funding digital support approaches and accessibility (hardware, connections, training) for people with lived experience, their families and carers

(b) navigation of outpatient and community mental health services from the perspectives of patients and carers

The mental health system is difficult to understand and to navigate, even for those who work within the system, like Flourish Australia.

Family and carers tell us that the system is difficult to understand and navigate. They often look to organisations like Flourish Australia to educate and support them to identify what supports might be required for their loved one, as well as for themselves.

Supports for family and carers are lacking. Understanding that family and carers are often the major source of support for someone with a lived experience it is very important that the mental health system better recognises this, and funds specific services to provide family member and carers with education and supports, assistance with navigation (such as Family and Carer Peer Workers), as well as opportunities for respite from the demands of being a carer.

The work of Mental Health Carers NSW[3] is very important in this regard.

Funding for mental health services should include a focus on the supports provided to family and carers, including more emphasis in programs on growing the number of family and carer peer workers. Educating and supporting family and carers has a direct impact on their own mental health and resilience, as well as their ability to provide ongoing supports to someone with a lived experience.

In stating this is it also noted that those providing care to other with a lived experience often also have a lived experience.

[2] See: https://www.who.int/health-topics/health-equity#tab=tab_1

[3] See: https://www.mentalhealthcarersnsw.org/

One of the greatest challenges for navigation is often a lack of services that provide alternatives to Emergency Departments, the Community Mental Health Team or an admission to hospital.

There are successful alternatives to these options such as the Resolve Program, based on peer operated services[4], and Warm Lines which provide access to non crisis, emotionally supportive telephone supports after hours[5].

Possible changes:

- Make more dedicate peer navigators available for people with lived experience and families and carers
- Fund specific Family and Carer Support Programs
- Grow the Consumer and Family and Carer Peer Workforces across public mental health and community managed organisations

(c) capacity of State and other community mental health services, including in rural, regional and remote New South Wales

Capacity of mental health services across the state is stretched. This particularly becomes the acute in rural, regional and remote settings in NSW.

From a community managed organisation perspective, workforce recruitment and retention challenges mean that significant vacancies remain unfilled for lengthy periods, impacting on the ability to deliver supports.

Similarly, pressures on public mental health services, including their own staffing challenges, often leads to difficulties in responding in a timely manner to requests for support.

However, whilst exacerbated by CoVID-19, these challenges of attraction and retention of qualified and skilled are not new, however when key positions cannot be filled it impacts significantly on what is possible.

Digital or technology delivered solutions are one part of an answer to bolstering capacity, but by its very nature mental health supports require experienced people on the ground, sitting with someone with lived experience their families and carers, and engaging, problem solving and agreeing a plan of action together. Expert clinical advice delivered from a remote setting may be somewhat assistive but will not address issues.

The lack of specific digital skills in workers and digital support models also hampers the use of digital approached to address capacity shortage issues.

In addition, mental health services should not been seen in isolation to other health services or indeed community resources. Often people with lived experience need more than clinical supports, extending to stable housing, employment, education and social and leisure opportunities. These are things that often provide people with productive engaging things to do, and nurturing and supportive relationships, that help build their ability to build skills and confidence, and provide a sense of hope.

The capacity of community mental health services generally is enhanced or diminished by any view that they operate in isolation to a coordinated, integrated ecosystem or government

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[4] Social Ventures Australia (2017). *The value of a peer operated service*. SVA Quarterly. See: https://www.socialventures.com.au/sva-quarterly/the-value-of-a-peer-operated-service/

[5] Dalgin, R.S., Maline, S., & Driscoll, P. (2011) Sustaining recovery through the night: impact of a peer-run warm line. Psychiatric Rehabilitation Journal. 35(1), 65-8. DOI: 10.2975/35.1.2011.65.68. See: https://pubmed.ncbi.nlm.nih.gov/21768081/

and other services and supports. Integrated supports are essential to a successful community mental health response.

We refer the Committee to our work on Flourish Australia's *Social Citizenship Framework*, inspired by work of Professor Michael Rowe at Yale University[6]. In this co-designed framework we comment:

> Flourish Australia recognises social citizenship as the responsibility of all stakeholders including Flourish Australia's workforce and other services, people with lived experience, the community, workplaces, learning environments, families, carers, kin, governments at all levels and the media. All people, working together to open up equitable opportunities for people to live contributing lives in their community, as part of family, friendships, with kin and in workplaces, learning environments, social clubs and neighbourhoods at all stages of their recovery journey. In short, social citizenship is about enjoying all human rights, including the right to be responsible.
>
> Social Citizenship focuses on and pursues positive social and community change and capacity building. It enables people with lived experience of a mental issue to live connected, contributing lives beyond trauma, stigma and discrimination, with or without the symptoms that often accompany psychological distress. Social citizenship honours people's choices about their own lives. It continues and builds upon the commitment to recovery-oriented practice, which celebrates each person's unique pathway and journey of life, recovery, wellbeing and contribution to family and community.
>
> Social citizenship highlights the importance of engaging with local organisations and communities to address inequitable, stigmatising and discriminatory responses to people's trauma and subsequent mental health issues. It recognises that individuals, families, kin and mental health organisations exist within a social network. Social citizenship requires that social network to ensure all people access equitable opportunities to meaningfully participate in, contribute to, and be valued by that social network.
>
> The deeply co-designed process used has led to the adoption of the concept of social citizenship to guide all that we do. For Flourish Australia, social citizenship is a concept involving the individual person, without relevance to their legal status, and the society in which they live. It encompasses ways of being and living in ones' community through: connecting, participating, contributing, feeling valued and enjoying a sense of belonging. This idea is reflected in our definition of this term.

(d) integration between physical and mental health services, and between mental health services and providers

The important focus on the integration of physical health and mental health services is relatively recent but incredibly important. Flourish Australia is a member and strong supporter of the work of the Equally Well and the National Consensus Statement[7].

In 2009/2010 we developed a physical health program as an early approach within the sector to address the physical health issues experienced by people with lived experience of a mental health issue, and the associated early mortality experienced. Called the Back on Track Program, the approach was to support the development of resources that supported people to self-manage their physical health, to connect them to a General Practitioner and help them know where to get information about various conditions that may support them to engage in conversations and decision making with their General Practitioner, with a focus on preventative health checks.

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[6] See: https://www.projectcitizenship.com/blog/citizenship-mental-health

[7] See: https://www.equallywell.org.au/wp-content/uploads/2018/12/Equally-Well-National-Consensus-Booklet-47537.pdf

This work was very important due to the regular reports by people with lived experience that their mental health diagnosis was overshadowing their physical health issues, and the physical health issues that needed to be addressed were not.

There has been significant improvement in the focus of integrated physical health and mental health services. We applaud the work of the Ministry of Health in this area in the *Guidelines on physical health care for people living with mental health issues*[8].

However, there remains less than adequate integration of physical health and mental health services and people with lived experience continue to die much earlier than their same aged peers.

The rise of so-called nutritional psychiatry[9] is notable in this context. The growing evidence of a link between what a person consumes, and their mental health is of increasing interest.

Nutrition and dietetics have long been an input into a comprehensive psychosocial support program, mostly focused on addressing issues in in relation to weight and weight gain, often due to medications and lack of exercise. The Your Body in Mind Program in South Eastern Sydney LHD[10] led by Dr Jackie Curtis, is a great example of a comprehensive program that assists people to avoid weight gain due to medications, promoting exercise physiology and dietetics as part of a multidisciplinary team as the gold standard approach.

Possible changes:

- Make exercise physiology and dietetics funding available as part of a comprehensive multidisciplinary community mental health approach in both public mental health services and community managed organisations

(e) appropriate and efficient allocation of mental health care workers, including psychiatrists, nurses, psychologists, GPs, councillors, social workers, allied health professionals and peer workers

Flourish Australia is a National Leader in the growth and development of the mental health peer workforce. We employ close to 2000 peer workers across our service footprint and programs. Importantly, we ensure peer workers are fully integrated into teams, alongside mental health workers.

We expect our staff to be qualified at the Certificate IV level – either with the Mental Health Work or Mental Health Peer Work qualification. This provides a good introduction into the important non-clinical psychosocial support work that people with complex mental health issues require to stay well and live in the community. This type of support focuses on housing, education, employment, relationship and social, leisure and recreation.

It is our view that peer workers and mental health workers are critical elements to a comprehensive multi disciplinary team. In our experience it is these workers who spend the most time providing supports to a person with a lived experience. More than any other worker in the mental health system. These workers support people to live contributing lives, supporting them to build skills and confidence to live in their communities of choice, and building the capacity of communities to be more inclusive and supportive, countering mental health stigma and discrimination.

[8] See: https://www.health.nsw.gov.au/mentalhealth/professionals/physical-health-care/Pages/default.aspx

[9] See Deakin Universities Food and Mood Centre - https://foodandmoodcentre.com.au/

[10] See: https://www.seslhd.health.nsw.gov.au/keeping-body-mind

In an environment where power is shared and each person's skills and experience are valued and seen as contributing, mental health workers and peer workers can have a significant positive impact on people's outcomes, their mental health recovery, and the work of a team.

Flourish Australia is passionate about the power of peer work, and has seen the way in which engagement with a peer worker can change people's experience of services, identify their personal recovery goals, and grow in confidence and hope.

We believe that there should be a significant focus on increasing the peer workforce in all mental health services. This workforce includes consumer peer workers and family and carer peer workers. We make this distinction between consumers and family and carer peer workers because of the different but valuable lived experience of each group, and the different focus of each type of peer worker's supports.

The power of the consumer peer workforce is demonstrated clearly by the published results of the Resolve Program[11], a totally peer run service in Western Sydney and Orange. Operated by Flourish Australia in partnership with, Social Ventures Australia, Nepean Blue Mountains LHD and Western NSW LHD mental health services, the service delivers a 24/7 Warm Line, a short term respite option and group and individual outreach supports.

Funded in part by a Social Benefit Bond, in addition to NSW Ministry of Health funding, the program has shown dramatic decreases presentation to Emergency Departments, hospital admission numbers and length of admission. These decreases being relative to the twelve months prior to joining the program. There has also been a reduction in the National Weighted Average Unit measure, a measure of resource utilisation in the health system.

In addition to these numerical outcomes, people have achieved great things including recommencing TAFE, getting a drivers license and getting a job. The positive personal impact of these achievements cannot be overstated.

It is noted that this program is time limited for each person to two years, with a no return policy. The funding of the program through the Social Benefit Bond is also time limited, ending in two years time (after a seven year life).

This shows that investment in totally peer worker delivered approaches deliver outstanding results for people and services, as well as the health system more generally.

Possible changes:

- Make Warm Lines available 24/7 across NSW to provide after hours supports for people with lived experience, especially when in times of acute distress
- Make peer operated services, staffed totally by peer workers, modelled on the Resolve Program, and part of an integrated community mental health service, available in each Local Health District

(f) the use of Community Treatment Orders under the Mental Health Act 2007

We make no comment about this topic, other than to reflect that coerced approaches to mental health supports would appear contrary to trauma informed, recovery-oriented supports.

[11] See https://www.socialventures.com.au/work/resolve-sbb/

We are aware of work being undertaken by Professor Lisa Brophy and colleagues out of the University of Melbourne about this topic and refer the Committee to their work[12].

(g) benefits and risks of online and telehealth services

Our experience of online supports is particularly derived from our experience of the COVID-19 pandemic and the immediate need to close service sites, and deliver supports remotely. We believe there are benefits to be accrued for providing access to technology and using it to deliver supports to people with lived experience. However, this cannot be seen as a panacea, a solution to the challenges of workforce shortages, or lack of funding. In our own experience people who access our supports have supported the introduction of online supports, but never as a replacement for face to face supports or as a way through which costs can be cut.

In our view, the use of online supports must be thoughtful, matched to persons need and introduced through shared decision making which considers the person and the support worker's ability to access, connect and use the technology. A face-to-face support cannot just be moved online with any expectation that its efficacy will be the same. The use of these services must also consider the availability of supports to address technology problems, as well as access to emergency responses if required.

As our CEO has commented elsewhere[13]:

> …the role of (online and telehealth services such as) telephone helplines and digital technology is an important avenue for exploration for the mental health system. The research is clear in that people with serious mental illness can use and do use technology, and they use it a lot, even in terms of finding information and support for their mental health issues. For example, people with a diagnosis of schizophrenia have been shown to use the internet to be an important source of information (Villani and Kovess-Masfety, 2017)[14].
>
> Whilst I agree that mobile mental health apps and digital technology is a big part of a future mental health system, particularly where young people increasingly use technology, the question is whether people with serious or complex mental health issues have access to, and can use the technology to access these supports. For example, Aschbrenner et al (2018) [15]investigated access to online and mobile technology by people with a serious mental illness within non-clinical peer support agencies in the USA. Across195 people with a serious mental illness in 10 agencies they found that 81% of respondents owned a mobile phone, 72% used text messaging, 58% used a smart phone and 72% used social media, 82% used the internet and 63% connected to the internet at the agency.
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> In Australia, looking at a group of people with serious mental illness connected to an inner-city mental health service, Thomas et al (2017)[16] found that 86% of

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[12] https://pubmed.ncbi.nlm.nih.gov/29463100/; https://www.frontiersin.org/articles/10.3389/fpsyt.2019.00414/full;

[13] http://rcvmhs.archive.royalcommission.vic.gov.au/Orr_Mark.pdf

[14] Villani, M. & Kovess-Mafesty, V. (2017). How do people experiencing schizophrenia spectrum disorders or other psychotic disorders use the internet to get information on their mental health? Literature review and recommendations. *JMIR Mental Health*, 4: e1. DOI: 10.2196/mental.5946

[15] Aschbrenner, K.A, Naslund, J.A., Grinley, T., Bienvenida, J.C.M., Bartels, S.J. & Brunette, M. (2018). A survey of online and mobile technology use at peer support agencies. *Psychiatric Quarterly*. DOI: 10.1007/s11126-017-9561-4.

[16] Thomas, N., Foley, F., Lindblom, K. & Lee, S. (2017). Are people with mental illness ready for online interventions? Access and use of the internet in Australian mental health service users. *Australian Psychiatry*, 25, 257-261. DOI: 10.1177/1039856217689913.

respondents owned a mobile phone, but only 51% had access to the internet services (a data plan) attached to their phone, and only 45% had access to the internet at home.

There is also a consideration as to what role technology plays in conjunction with face to face support, which often cannot be totally replaced. Therefore, in my view there needs to be some fundamental questions answered about how technology can be co-developed with people with complex mental health issues, and used effectively and respectfully in ways in which people feel they are being listened to.

One of the examples …in which technology has been used well is the use of online forums by SANE Australia; one for family members and carers, and one for people with lived experience. This is a great example of natural peer support in action in a digital space. A moderator is used to approve posts and monitor the information on the forums, but in my view it's a great way of facilitating connections between people that are sometimes long distances away who share their experience and information to support each other. I think it's an exciting addition to the service network.

Another one in its early stages of development is digital peer support, and specifically using technology to deliver peer support from paid peer workers. The challenge however, is that this requires access to the required hardware (e.g., a smartphone, computer), a data plan and access to the internet (…). All of these things cost money and require a degree of skill. My caution is that it can't be just accepted that people with complex mental health issues have this access to technology or skills; we might need to focus on how we facilitate those things if this approach is to be deliver on its exciting promise.

I am particularly interested in how we can use videoconferencing technology to deliver supports and specifically peer support. At its most basic level it would be using something like Skype or Zoom (though using a product that is more secure and protects people's privacy and the confidentiality of the interaction). My doctoral research is looking at access to technology, as well as the features and training required to transform a traditional in person experience of peer support to a digital space. Initial feedback from people with complex mental health issues and peer workers from focus groups that have been run is positive. Both groups are very interested and supportive, and see the promise.

If we can use technology in the right way then in my view it will provide significant improvements to the delivery of mental health services, particularly for people who live remotely or cannot easily connect with supports for whatever reason.

Further, in my view, any approach using technology must be co-developed with people with lived experience, by asking them how to create the best possible experience for somebody; an experience that delivers the supports they need not what someone else thinks they do.

Possible changes:
Equity of access could be improved by using:

- More co-production in community mental health service and support models development including digital support approaches

- Funding innovative approaches to community based services using digital / online supports
- Funding digital support approaches and accessibility (hardware, connections, training) for people with lived experience, and their families and carers

(h) accessibility and cultural safety of mental health services for First Nations people, culturally and linguistically diverse (CALD), LGBTQIA+ people, young people, and people with disability

It must be acknowledged that mental health services have been focussing a lot of resources and effort in these areas, with the goal of improving accessibility, and cultural safety and responsiveness. Great strides have been made, however, much more is needed to be done.

Appropriate funding and focus across services is required to make the fundamental changes required to deliver seamless health services required.

Different models of service are required to meet the unique needs of each of these groups, Some, such a First Nations services, need to be based more on different ways of knowing and knowledge systems. Different approach to healing and support within community and on country[17] guided by Elders and Cultural Healers.

In our view, a stronger focus in mental health services on the Gayaa Dhuwi (Proud Spirit) Declaration[18] with appropriate commitment, leadership and funding to facilitate its full implementation, would have significant impact on accessibility and cultural safety in these services.

LGBTIQA+ people continue to report challenges with accessing safe services, an area ACON's Pride in Health and Wellbeing Program[19] is attempting to address by supporting health and social services improve their cultural approaches.

We commend the Ministry of Health's work on the development of the NSW LGBTIQ+ Health Strategy 2022-2027[20]. However, it is very new, and requires continuing and enhanced longer term investment if it is to achieve its important goals, including :

> 1.3 Mental health and suicide prevention - Increase access across LGBTIQ+ people's lifespan to mental health and suicide prevention services and supports

It is important to comment in this context of the fundamental importance of co-production of services, and service and supports models, that seek to address accessibility and cultural safety of mental health services.

Possible changes:
- Implement the Gayaa Dhuwi (Proud Spirit) Declaration in all public mental health services and community managed organisations, providing funding for implementation
- Enhance funding for new service models of First Nations social and emotional wellbeing, and cultural healing programs led by communities

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[17] See Dudgeon, P, Milroy, H & Walker, R. (2014). Working together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. https://apo.org.au/sites/default/files/resource-files/2014-05/apo-nid39689.pdf

[18] See https://www.gayaadhuwi.org.au/

[19] See: https://www.prideinhealth.com.au/ Flourish Australia is a Founding member of Health and Wellbeing and our CEO is the Chair of the Advisory Group.

[20] https://www.health.nsw.gov.au/lgbtiq-health/Pages/lgbtiq-health-strategy.aspx

- Enhance funding for the NSW LGBTIQ+ Health Strategy 2022-202 specifically focussed on community mental health supports delivered by public mental health services and LGBTQIA+ community organisations

(i) alternatives to police for emergency responses to people experiencing acute mental distress, psychosis, delirium, dementia or intoxication in the community, including but not limited to Police, Ambulance, Clinical, Early, Response (PACER)

We do not believe police are equipped to respond alone to any of these emergencies. They do not have the qualifications, skills or experience to do so, and it is unfair and unreasonable to expect them to respond effectively. Their role as protecting public safely is acknowledged, but it must also be noted that people with lived experience often have had a poor experience of interactions with police. A more thoughtful expert supported approach is required.

As our CEO has commented elsewhere[21]

> I understand the PACER (Police, Ambulance and Clinical Early Response) model, a joint crisis response from police, ambulance and mental health clinicians, was used to respond to people experiencing a crisis, and I think this is a good example of trying to have more involvement of mental health specialists at a critical time. The model is about recognising that we shouldn't expect police to manage what may be a mental health crisis alone; they can assist with ensuring safety but the mental health specialists can provide the required expertise and advice on how best to support the person in mental health "crisis". I would suggest there may also be an opportunity to explore an enhancement of that model to provide a role for specialist peer workers who may be able to connect with somebody in a highly distressed or agitated state, hopefully making the experience in that moment and presentation to an emergency department less traumatic for the person.

As noted, whilst some models focus on the use of mental health clinicians in these responses, and important improvement, we believe there is also potential for the positive involvement of peer workers in responding to these situations. The ability of peer workers to connect, reassure and de-escalate situation is a skill that could be used to significant positive effect.

We supportively refer to the Committee to our colleagues at Being Mental Health Consumers and their reflection on this issue in their submission, where they state:

> Peer workers have both lived experience and learned experience in supporting people experiencing a mental health crisis, as evidenced by the successful Safe Havens run by peer workers across the state. Peer workers are also skilled at working in multidisciplinary teams, for example within the SPOT (Suicide Prevention Outreach Teams) program where a clinician and peer worker pair up to respond to people experiencing suicidality. It would be appropriate for peer workers to work within multidisciplinary emergency services teams in responding to crises. (p12)

Possible changes:

- Investigate the possibility of introducing a PACER–type model across NSW, including the use of specialist peer workers, as part of a multidisciplinary emergency response

(j) any other related matter.

We believe accessibility to community mental health supports would be dramatically increased with a reconsideration of the investment in mental health services. A continuing

[21] http://rcvmhs.archive.royalcommission.vic.gov.au/Orr_Mark.pdf

focus on clinical supports and beds and poor investment in community based mental health supports services – both public services and community managed services – is a continuing lost opportunity for delivering more equitable access to mental health supports in NSW.

We remind the Committee of the National Review of Programmes and Services undertaken by the National Mental Health Commission in November 2014[22]. That report recommended, amongst other things:

> Reallocate a minimum of $1 billion in Commonwealth acute hospital funding in the forward estimates over the five years from 2017–18 into more community-based psychosocial, primary and community mental health services.

Disappointingly, that recommendation was not taken up by the Australian Government at the time. However, in our view, its promise holds true.

More investment in the community managed sector will deliver great outcomes for people with lived experience in partnership with community mental health teams. As evidence, we refer the Committee to the 2022 Evaluation of NSW Community-based Mental Health Programs: HASI and CLS[23]. This is a great model that delivers the focus of the Committee's inquiry - equity, accessibility and appropriate delivery of community mental health care in New South Wales.

Our experience, some of which is outlined here, demonstrates that community based mental health supports make a real difference to the lives of people with lived experience, and their families and carers, and reduces their need to access acute care clinical supports. It also prevents additional trauma and facilitates people's recovery and sense of hope.

4. Contact:

For more information please contact:

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[22] See: https://www.mentalhealthcommission.gov.au/getmedia/6b8143f9-3841-47a9-8941-3a3cdf4d7c26/Monitoring/Contributing-Lives-Thriving-Communities-Summary.PDF
[23] See: https://www.health.nsw.gov.au/mentalhealth/resources/Pages/cls-hasi-eval-2022-overview.aspx