Submission to the NSW Special Commission of Enquiry into Healthcare Funding

DATE **15 November 2023**

Authored by:

Dr Richard Baldwin richard.baldwin@mentalhealthcarersnsw.org Mob. 0402894427
Mr. Jonathan Harms jonathan.harms@mentalhealthcarersnsw.org Mob. 0401169921

https://www.mentalhealthcarersnsw.org/

Introduction

This document

This paper is a submission to the NSW Special Commission of Enquiry into health funding. Following an invitation two officials (Mr. Jonathan Harms and Dr. Richard Baldwin) representing Mental Health Carers NSW met with the Commission on 1 November 2023 via audio visual link. During that meeting the Commissioner urged Mental Health Carers NSW to make a written submission. This submission is in response to that request.

About Mental Health Carers NSW

As the peak body for mental health carers in NSW, MHCN represents the interests of mental health carers to the NSW Ministry of Health, and provides information, capacity development and systemic advocacy on behalf of mental health carers. It regularly consults with carers across NSW to gain information on their opinions and experiences with the mental health system. MHCN uses the information gained in these consultations to provide feedback on policies and services on behalf of carers to NSW Health and to other health services and policy makers. With its core functions funded by the Mental Health Branch of NSW Health, MHCN developed the Mental Health Carer Advocacy Network (MHCAN) to broaden its engagement with mental health carers in its advocacy and to assist roll out of the NSW Lived Experience Framework.

By influencing changes in policy, legislation, and service provision, MHCN aims to make a positive difference to the mental health system for carers and through the MHCAN to empower carers to become champions for change, sharing their lived experience to evoke the solidarity of humanity to promote mental health reform.

In October 2022, MHCN was awarded the tender for Department of Communities and Justice Disability Advocacy Futures Program (DAFP) for psychosocial disability systemic advocacy. Over the next two years, MHCN will deliver systemic advocacy through this project that includes liaising with Individual Advocacy Providers, stakeholders, government, and non-government decision-makers, and DCJ to improve understanding of the unique issues faced by people with psychosocial disability. This Policy Manager role will also coordinate MHCN's general carer advocacy program with the psychosocial disability advocacy in the Policy and Advocacy Team.

MHCN Response to the Terms of Reference

The following table provides our response to the terms of reference of this enquiry.

Terms of Reference	MHCN Submission
A. The funding of health services provided in NSW and how the funding can most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care and health services to the people of NSW, now and into the future;	See below
B. The existing governance and accountability structure of NSW Health, including:	
i. the balance between central oversight and locally devolved decision making (including the current operating model of Local Health Districts);	Key Points • A major structural flaw in the current health system is the separation of planning and funding of commonwealth and state health systems and the lack of shared clinical governance frameworks that can cross the boundaries created by having different levels of government fund different levels of health care. NSW lacks the tools and platforms to support the cohesive and coherent delivery of especially chronic care of all kinds when this care must be delivered both in hospital and in the community from time to time. • Structural change to the health system *(reorganisation of funding, administrative, and governance boundaries for hospitals and community health services)* is very disruptive for health service delivery and should be avoided unless necessary for demonstrated improved service delivery; that is, the lure of potential financial savings is insufficient reason, on its own, to reorganise existing administrative arrangements.

Terms of Reference	MHCN Submission
	• NSW Health has enjoyed a decade of relative structural stability and the Local Health District system is a significant improvement over the model of large Area Health Services it replaced. • The ideological model that drove the current structure of the Ministry and associated 'pillars' emphasises efficiency over quality and access and has resulted in a significant lack of centralised health services planning and decision making. • Resolution of some issues related to equitable access to health services are beyond the capacity of local planning and decision making. A major structural flaw in the current health system is the separation of planning and funding of commonwealth and state health systems. This has an especially acute impact on mental health, but the lack of systemic planning impacts all areas of healthcare and especially chronic care of all kinds, where long term care requirements cross care settings and care providers and therefore the responsibilities of state and commonwealth funders. Ideally planning, service delivery and funding should look at what people need in health and other services across the life span and identify gaps. Decision making about service and funding needs to be data driven examining both unmet and met needs and then makes assessments about what needs to be addressed by the different tiers of government. The major challenge to make this work is the split of responsibilities between the Federal and State Governments over health service funding. Because commonwealth funded health services, such as Medicare, rely on 'fee-for-service' payments and the state-based services rely on block grants there are competing pressures that make fully integrated planning, funding and decision making difficult and the overall system does not meet the community's health needs. While outside the scope of this Enquiry this split of responsibilities creates major challenges for individuals and often results is a failure to access services or accessing services at considerable personal cost. Access to ambulatory mental health services across Australia provides an excellent example of the gaps, overlaps and differences in costs to consumers is access. NSW health funds and operates an extensive system of community mental health services. These services prioritise people with serious mental illness and do not have the capacity to cater for people with less severe symptoms. The Commonwealth funds psychology services through Medicare and through the Primary Care Networks. However, joint planning between Local Health Districts and Primary Care Networks is rarely done well in

Terms of Reference	MHCN Submission
	NSW. This results in a mal distribution of the availability of service which is particularly challenging for people in lower socio-economic locations who cannot afford private services even if they were available. Although there are notable exceptions. The Productivity Commission Review into Mental Health in 2020 argued for joint service planning and commissioning at the regional level between Local Health Districts and Primary Health Networks (redesigned to give them this specific purpose) and to a degree this has been trialled by the Central and Eastern Sydney Primary Health Network in collaboration with Sydney and South –Eastern Sydney Local Health Districts in their Mental Health and Suicide Prevention Regional Plan, (Implementation Report and Evaluation Reports attached). However, to fix our health systems we need data driven health services planning at the population level in strict collaboration between the Commonwealth, state, and regional/local level in coordination with other human services if we are to achieve a truly cost-effective health system, accessible and sustainable for all. Senior staff of MHCN have witnessed policy preferences of different NSW governments shift between decentralisation and centralisation of planning and decision making. Prior to the change in government in 2011 there was, arguably, an overreliance on centralisation within the (old) NSW Department of Health. This led to political influence in decision making at the local level and a lack of delegated authority for local managers to make appropriate decisions to be responsive to local needs. The last decade in NSW has seen stability in the structure of the delivery system in NSW. While this is a positive development it is unusual. In most of the last five decades there has been significant structural changes within NSW Health. These changes were: • 1970s – amalgamation of the Department of Public Health and Hospitals Commission to form the NSW Health Commission and the formation of Regional Offices of the Health Commission • 1980s – the dissolution of both the Health Commission (replaced by the Department of Health) and the dissolution of the boards of individual public hospitals in Sydney, Newcastle and Wollongong to be replaced by 23 Area Health services. After two years the 23 were amalgamated into 10 larger Area Health Service. • 1990s – hospital boards in rural and regional areas of NSW were replaced by 23 Health Districts in 1993 and these were replaced by eight Area Health Services a few years later.

Terms of Reference	MHCN Submission
	• 2000s – the 18 established area health services were replaced with eight very large Area Health Services. This proved to be unwieldy and universally unpopular. • 2010s – in 2011 the Department of Health was replaced by the Ministry of Health and the eight Area Health Service structures were replaced by the current 18 Local Health Districts and Networks. This reform also introduced the five 'pillar' organisations which sit outside the Ministry and provide support and guidance across the whole NSW health system. The Ministry model follows a neo-liberal approach to public administration which favours smaller central departments, devolution of decision making, an emphasis of improved efficiency, a belief in the value of markets, and an alleged focus on improved consumer experience. Of lower importance in a neo-liberal framework are concepts such as quality, equitable and accessible access, as these concepts tend to conflict with efficiency goals. Because of these structural changes, driven by these ideological preferences, the Ministry has moved away from centralised planning and left the bulk of health services planning to the Local Health Districts and Networks. There are limitations to this model, primarily in relation to consistency of service delivery across the state and when 'big' decisions need to be made in relation to capital works and the future of institutions. In following this ideology, the old Department of Health was significantly downsized and transformed into the Ministry of Health with an emphasis on greater devolvement of decision making to the newly established Local Health Districts. The establishment of the 'pillars' (at the same time) had, arguably, resulted in a retention of many staff engaged in central governance, albeit structurally outside the Ministry of Health. While there are many benefits to the specialisation of the 'pillar' system, of concern is the increased 'transactional cost' for local health districts which now not only have the manage communications with the many branches of Ministry of Health *(including Health Infrastructure, Healthshare, NSW Health Pathology and eHealth)* but must also contend with the considerable volume of communications from the quasi-independent 'pillars'. This model has resulted in the delivery of excellent guidance to local health districts in some areas of clinical care, electronic health systems and education, however there are numerous examples of inefficiencies competing priorities and 'gaps' in corporate governance (*for example, human resources management, up to date policy directives and a lack of central planning)*.

Terms of Reference	MHCN Submission
	These continuing structural changes of local health service have been significantly disruptive to service delivery. Each restructure inevitably results in large scale redundancies of managers at all levels, and it takes years for all the new administrative positions to be filled with permanently appointed staff. This results in many 'acting' managers, particularly in lower tiers of management, as all the management levels above them must be filled with permanent appointments first. Inevitably legacy systems remain, for example, some components of the electronic medical record system in Local Health Districts still feature functional elements that reflect the old Area Health Service model which was dismantled over a decade ago. At Mental Health Carers NSW, we believe that good decision making cannot take place without appropriate planning and that effective health care planning should come before health care funding. Funding is more likely to be inappropriate when it is not clear what services should be funded and where. One challenge with health services planning and decision making is to determine the level at which planning takes place. There are limitations when all planning and decision making is undertaken at the state level and different limitations when all planning is undertaken at the local level. Sound government decisions arise when coordinated appropriate planning takes place at both levels. A major concern of our members is the inconsistency of service deliver across NSW which can often be traced through different funding provision. These are long standing anomalies in the distribution of service established prior to the current Local Health District structural arrangements. For example, some people with severe mental illness do not respond to treatment and must remain in hospital for a long period. South Eastern Sydney and South Western Sydney Local Health Districts have few if any dedicated long-term care beds for these people with chronic mental health conditions. On the other hand, Northern Sydney and Western Sydney Local Health District have free-standing, legacy, mental health hospitals (Macquarie and Cumberland) that have many dedicated long stay mental health beds. Carers, our members at MHCN, express frustration when the person they care for must be transferred outside the local health district, sometimes long distances, to obtain the most appropriate treatment and accommodation. Poor equity of access is also apparent in the availability of mental health intensive care beds, child and adolescent mental health service, older persons mental health services and rehabilitation beds. The current system of planning and funding seems unable to rectify this mal distribution of services.

Terms of Reference	MHCN Submission
	Health service planning is a special discipline within health services management with several Australian universities offering post-graduate courses. Health services planning is essential data driven using population, epidemiological and morbidity statistics as a basis for planning. It is essentially about numbers. However, what now constitutes 'planning' within the Ministry of Health is largely focused on strategic planning and policy statements sometimes combined with guidelines. Although there is available from the Australian Institute of Health and Welfare a planning tool for mental health services - *The National Mental Health Service Planning Framework (NMHSPF)* – there is little evidence that this tool is used in NSW Health for planning mental health services. This is probably because any calculation of need made by the application of this tool must then be funded and it is not clear that this routinely occurs as this is a political decision. Publication of the results of the application of this tool and then transparency about the amount of funds provided to LHDs for different classes of care (like mental health) and then publication of what was spent on it might go some way to address this issue at least between different classes of care. The consequences of a lack of solid centralised planning is that local health districts are left to undertake their own planning and smaller LHDs often struggle to undertake this work. Naturally health service planning at the local level is not capable of overcoming gaps in service delivery between LHDs and across NSW and a consequence is the continuing mal distribution of services across NSW. What is needed is the creation of a reasonable balance between local and centralised planning upon which sensible funding decisions can be made.
ii. the engagement and involvement of local communities in health service development and delivery;	Key Points • Local Health Districts by their nature struggle to engage local communities at a level that enables communities to productively influence major decisions. • Mental Health Carers NSW is structured to assist Local Health Districts to consult with mental health carers but is rarely asked by LHDs to do so. Engaging local communities is a 'holy grail' of every health service strategic and business plan but is often honoured in the intention rather than the delivery. This is because done properly it is very time and resources consuming. Health service managers and executives often struggle to justify the resources they need to allocate to this task amid criticism they are moving resources from direct patient care.

Terms of Reference	MHCN Submission
	Local communities can be strongly parochial when asked to participate in health service development and delivery. They tend to want to hang on to the institutions they know and are familiar with and object to complex now proposals about which they have little experience. A good example of the difficulty in securing community endorsement of major changes to health service delivery is the 20+ years of community consultation by the Northern Sydney health authority (by various names over the period). this consultation continued until the final decision was made to close Mona Vale and Manly Hospital and amalgamate these resources into the new Northern Beaches Hospital in Frenchs Forest. The chaotic commencements of operations of the new hospital consolidated in the minds of many locals that the wrong decision had been made. Prior to their dissolution in the late 1980s and 1990s, hospital boards tended to consist of local community members appointed by the Minister. Being local, the board had closer links the community it served than the boards of currently configured Local Health Districts. The old model of local hospital boards had many deficiencies and there should be no consideration of a return to this model, however, one of its strengths was the capacity to engage with communities for solid local consultation. Local Health Districts and Networks now have primary responsibility to engage with local communities, but their boards now consist primarily of individuals drawn from business and professions who may have only a fleeting link to the community the LHD serves. Some LHDs cover large areas which constituting many different communities making local consultation challenging. When local communities are involved, they are often asked to consider only relatively minor aspects of health service planning and decision making. Major decisions are often made within the Ministry and announced. Mental Health Carers NSW has a network of carers around NSW on our register and we regularly engage with mental health carers around planning issues with organisations. In the past year we have undertaken discussion forum for the Audit Office of NSW, the Department of Communities and Justice, the NSW Ministry of Health to name a few. However, we are rarely asked by Local Health Districts to assist them in consultations with their local communities.
iii. how governance structures can support efficient implementation	A key vehicle for the delivery of evidence based clinical care is a sound clinical governance system. We cannot get to cost effective unless we achieve effective first, but to do this we need funding models that

Terms of Reference	MHCN Submission
of state-wide reform programs and a balance of system and local level needs and priorities;	reward good medical practise, including prevention and treatment of illness or distress at the earliest, lowest level of acuity when it is cheapest and easiest to do. However, that means also having the different providers of different levels of care being well tied in to agreed models of care that cross levels of acuity and efficiently use primary care, community care and specialist and in-patient services in a coordinated fashion. A particularly stark gap in the current delivery of health services in Australia and NSW is the absence of capacity for such care coordination through shared systems and liaison staff, much less coherent care coordination tools, protocols or mechanisms. We attach shared care guidelines for community mental health services and general practitioners as an example of the kinds of gaps that need to be consistently filled across health care in this country.
iv. the impact of privatisation and outsourcing on the delivery of health services and health outcomes to the people of NSW;	Key Points • the most significant example of privatisation and outsourcing in NSW in recent years has been the private public partnership to build and operate Northern Beaches Hospital under the previous government. • A NSW Parliamentary Enquiry recommended in 2020 that no such arrangements should be entered into again in NSW. One example of privatisation and outsourcing in NSW is the contracting to Healthscope for the building and operation of the Northern Beaches Hospital. This hospital opened in …. And was the subject of a NSW Parliamentary enquiry in 2020. While the report of the Parliamentary enquiry has several recommendations, recommendation 22 is the most interesting: 'that the NSW Government does not enter any new public private partnerships for future public hospitals' [1] Feedback from our members suggest that, despite the NSW government's response to the Committee's report, significant concerns remain. These include differences in the care and treatment of public and private mental health patients, lack of responsiveness for mental health patients attending the emergency department, a reduction in staffing levels compared with other suburban hospitals of a comparable size, inefficient referral practices between the hospital and the community mental health services (which are operated by the LHD).

[1]. NSW Legislative Council. Portfolio Committee No. 2 – Health. 2020, *The operation and management of the Northern Beaches Hospital*, New South Wales Parliament [Sydney, N.S.W.]

Terms of Reference	MHCN Submission
	We are aware of some local arrangements between LHD operated mental health services and nearby private hospitals with mental health beds for the 'outsourcing' of a small number of patients in other parts of NSW. These arrangements appear to work well.
v. how governance structures can support a sustainable workforce and delivery of high quality, timely, equitable and accessible patient-centered care to improve the health of the NSW population;	
C. The way NSW Health funds health services delivered in public hospitals and community settings, and the extent to which this allocation of resources supports or obstructs access to preventative and community health initiatives and overall optimal health outcomes for all people across NSW;	Key Points • Mental health carers provide unpaid care to a value higher than the paid care of all levels of government in Australia. • The NSW government provides very little funding to support mental carers whose unpaid care keeps numerous people with mental illness out of hospital. • Despite decades of rhetoric there is still an imbalance between expenditure on expensive inpatient services at the expense of prevention, early intervention and community-based services. • Mental health services in NSW have achieved a relatively efficient system of vertical integration but have a poorer record of horizontal integration. **Value of unpaid mental health carers** In its final report[2], the Australian Productivity Commission recognised the contribution made by informal carers towards the care of people with a mental illness in Australia. Table 1, (p11), reports that the total cost of all government expenditure on mental health care in Australia in 2018-19 was $9.7 billion while the value of informal care across Australia in the same year was $15.3 billion. That figure is the estimated cost of what governments and individuals would need to pay if all families and carers ceased to provide unpaid care and this role fell to government funded providers.

[2] Productivity Commission 2020 Mental Health Report No. 95, Canberra

Terms of Reference	MHCN Submission
	A rough estimate of the current benefit to the NSW community of the value of the informal care provided by families and carers to people with a mental illness in 2023 is $5.5 billion[3]. 'The budget for mental health services in 2022-23 was $2.9 billion'[4]. However, on the page of the NSW Health website where this quote is be found, there is no mention of any funding directed to support mental health carers in 2022-23[5]. **Inadequate funding to exiting carer services** MHCN acknowledges the financial support provided to us for operational expenses by the Ministry of Health. However, we are a peak body and consequently not funded to provide support to individual mental health carers. NSW Health also funds the Family and Carer Mental Health Program across NSW which is an advisory service provided through five community-based organisations. There services are well used by mental health carers but are limited to education, counselling and advice to carers. The NSW health system provides little in the way of practical or financial assistance to mental health carers. These contributions to these two organisation are miserly compared with the cost savings gained by the NSW government through the free care and support provided by families and carers which keeps people out of hospital and health services. There are numerous areas when funding can be provided to support families and carers: providing respite services, expansion of day care activities, and there are big gaps in the psychological supports needed by carers of all kinds and mental health carers in particular, given the high levels of psychological risk of the caring role. A recent evaluation of the FCMHP demonstrated that the funding for this program has fallen well short of population growth (as is the case for most mental health services which seem to have little allowance made for demographic changes in their routine funding calculations. **Imbalance of expenditure on inpatient services**

[3] Estimate based on NSW population approximately one third of Australia adjusted for inflation of 10% 2019 – 2022.
[4] Mental health budget - Mental health (nsw.gov.au) downloaded 10 November 2023.
[5] NB the NSW Health website does not provide a breakdown on the 2023-24 mental heath budget at the time of writing this report.

Terms of Reference	MHCN Submission
	As a rule, medical care should be provided as early as possible, even before problems arise where possible (prevention), in order to minimise suffering, reduce disability and risk and to resolve the medical issues as quickly and cheaply as possible. Inpatient services are acute services which typically deal with very serious medical problems when they are well advanced and difficult and expensive to treat. This is especially so in mental health, where the absence of effective community treatments for mental distress means people routinely are denied access to care until they are very sick, have suffered extensively and are difficult and expensive to support to recovery. Because community, primary, inpatient and specialist services are funded by different levels of government the attempts to cost shift means the public get a substandard, disconnected system that denies assistance until the last possible moment to the massive cost of all. **Poor horizontal integration of mental health services** Mental health services have a good level of horizontal integration (between non-hospital and hospital-based services). Community mental health services generally have developed good relationships with inpatient mental health facilities and emergency departments. While these relationships may not be as effective as possible the hospital-based services and community mental health services have a good knowledge of each other and how to make effective referrals. However, horizontal integration of community mental health services with other community-based services such as general practitioners, NDIS service providers and private practitioners are not, overall well developed. Community mental health services often report poor integration with Primary Health Care Networks. Although often located in the same suburb or town, community mental health staff often struggle to establish effective relationships with general practitioners concerning shared patients. Community mental health staff report that there are poor incentives for general practitioners to engage with the community mental health staff. Community mental health staff rely on the effective transfer of care to general practitioners of stable consumers tom other providers such as general practitioners as they are constantly required to respond to new referrals. Unlike general practitioners and other private mental health providers community mental health services do not have the luxury of refusing to accept referrals. Because community mental health services are funded on a block grant financial allocation, and not on a case volume/case mix basis, there is no capacity to expand their capacity to accommodate more referrals. This inflexibility of funding force most community mental health service to ration services to the consumers who are the most seriously ill leaving a gap of less severe but still needy consumers who don’t

Terms of Reference	MHCN Submission
	receive the level of care and treatment that they need to stay well and out of hospital. Carers continually report a lack of capacity and responsiveness by the community health team unless there is a crisis. Rationing care in this way maximises the risks to the wellbeing of the carers and their loved ones, as well as maximising the experience of illness, disability and morbidity experienced by members of the community and maximises the costs of providing health care to them too.
D. Strategies available to NSW Health to address escalating costs, limit wastage, minimise overservicing and identify gaps or areas of improvement in financial management and proposed recommendations to enhance accountability and efficiency;	Key points • The inability of emergency and mental health departments in public hospitals to work together results in much longer stays in the emergency department for people with acute mental health symptoms and behaviours than is necessary in a more cooperative system. • The lack of supported accommodation in the community results in many consumers spending months/years in a mental health ward of a public hospital at a much higher daily cost. We are not aware of any areas in mental health services in NSW where there are opportunities to save on wastage. However, there are numerous examples of where there are inappropriate expenditure or gaps in services. One significant area where there is inappropriate expenditure is relation to the care and treatment of people with mental health issues in general hospital emergency departments. People with acute mental health symptoms and related behaviours when attended to by the police and ambulance, or their families or carers, are taken to the nearest emergency departments gazetted as a 'declared mental health facility' under the *Mental Health Act 2007 NSW*[6]. Emergency Departments in this category can detain consumers under the Act for up to 12 hours until they are seen by a mental health clinician and either admitted to the mental health ward or discharged. The inappropriate expenditures arise due to the incapacity of the mental health team to attend in a timely manner to the patients newly arrived in the emergency department. Distressed consumers, and their carers, are often required to wait several hours, sometimes overnight, before being assessed. Regularly these consumers become more disturbed and at times aggressive due to the long wait. Invariably they

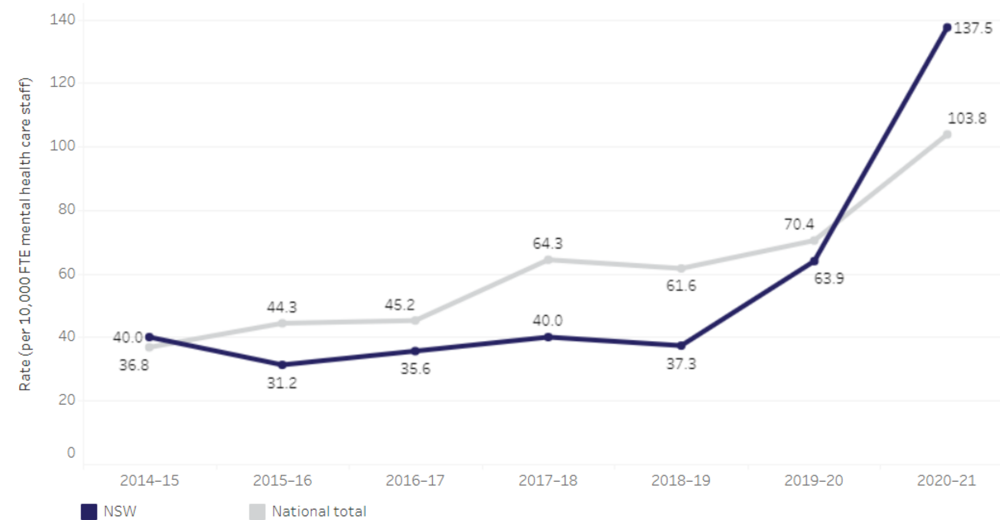
[6] s 109

Terms of Reference	MHCN Submission
	need to be restrained – either physically, mechanically, or chemically, until the mental health team arrives. Not infrequently by the time the mental health clinical professional arrives in the Emergency Department (*the mental health team in most hospitals are not part of the emergency department staff and must be paged to attend the emergency department*) the consumer has been sedated and cannot be assessed. This then prolongs the period they are in the emergency department as the mental health professional will decline to assess them until the sedation has metabolised sufficiently for the person to asked questions and respond in a manner that enables an appropriate assessment. The inappropriate expenditures arise due to the inappropriate length of time the consumers are kept in the emergency department, the additional care required when their behaviour escalates due to the long wait, the negative experience of the consumer and their families, who next time the persons symptoms recur are reluctant to engage the public health system until the persons illness has escalated to the point that multiple agencies need to become involved. A more smoothly working system between the emergency and mental health departments would save money for both services. Another area of inappropriate expenditure is the lack of appropriate long term secure housing in the community for people with chronic psychosis. The lack of available housing results in consumers staying in long term acute hospital care often for several months, at times years, when they could be cared for more appropriately in supported accommodation and a much lower cost.
E. Opportunities to improve NSW Health procurement process and practice, to enhance support for operational decision-making, service planning and delivery of quality and timely health care, including consideration of supply chain disruptions;	No comment
F. The current capacity and capability of the NSW Health workforce to meet the current needs of patients and staff, and	No comment

Terms of Reference	MHCN Submission
its sustainability to meet future demands and deliver efficient, equitable and effective health services, including:	
i. the distribution of health workers in NSW;	Kay Points • Mental Health Peer Workers have made a significant contribution to the care and treatment of consumers with mental health issues in acute mental health inpatient units and in some community mental health services. • Evidence support the financial benefits of providing peer workers • Distribution of peer workers across NSW mental health services is patchy and uneven. Some LHDs have been slow to introduce this new category of worker and there has been some resistance from traditional health care professionals. • NSW is significantly behind other states in the introduction of carer peer workers who are employed in mental health services to specifically engage and support carers. '*A consumer peer worker is a person who has lived experience of a mental health issue and is employed to use this experience to work with others who are recovering from a mental health issue. A carer peer worker is someone who has lived experience of caring for someone with a mental health issue and uses their experience to support others who are caring'*[7]. Peer workers draw upon their own personal lived experience of mental illness to provide authentic engagement and support for people accessing mental health care. Peer workers are in a unique position to build connections and rapport with people by inspiring hope and role modelling recovery. They provide individual and group peer support, recovery planning and goal setting. They also help with navigating the mental health service system, and individual and systemic advocacy. The following table illustrates that in 2020-21, there were 137.5 FTE consumer peer workers per 10,000 mental health care staff, up from 63.9 FTE in 2019-20. NSW is now above the national average of 103.8 5 FTE consumer peer workers per 10,000 mental health care staff. Despite these positive figures the number

[7] NSW Mental Health Commission, 2023, downloaded from https://www.nswmentalhealthcommission.com.au/measuring-change-indicator/mental-health-consumer-and-carer-peer-workers on 13 November 2023

Terms of Reference	MHCN Submission
	of peer workers is still very low compared with other categories of mental health staff and increase in the number of peer workers has the potential to produce further savings to the mental health system.



There are two emerging speciality areas within the peer worker category: peer navigators and carer peer workers.

Peer Navigators provide a broader role than peer workers as they assist the consumer to 'navigate' the mental and physical health care systems. They are particularly helpful in assisting consumers with complex needs to plan and access the services they need both within the hospital and the community.

Terms of Reference	MHCN Submission
	An evaluation The NSW Ministry of health funded the Peer Supported Transfer of Care (STOC). The Peer-STOC program was independently evaluated in 2020-21 by the University of Sydney, in partnership with the Australian National University. The evaluation found the Peer-STOC program reduced 28-day readmission rates, improved community contacts, improved consumer experiences of service and recovery outcomes, and had a net budget impact (saving) of $1.85 million over the first 3 years of the program[8]. Carer Peer Workers focus on providing support for carers to assist them to continue providing unpaid care for consumers with mental health issues. As argued above, carers contribute significantly to the overall care of people with a mental health issue and save the NSW government from the expense of providing the care that would be necessary if carers failed to continue to support the people they care for. Carer peer workers play and important role assisting carer to continue with the caring role and to help them to navigate the mental health system. However, based on the latest available data there were only 4.1 carer workers per 10,000 mental health care staff in NSW in 2020-21, which is a significant reduction from the rate of 7.7 in 2014-15. The rates of carer workers in NSW remains significantly lower than the national average.
ii. an examination of existing skills shortages;	No comment
iii. evaluating financial and non-financial factors impacting on the retention and attraction of staff;	No comment

[8] NSW Health https://www.health.nsw.gov.au/mentalhealth/professionals/Pages/peer-workers.aspx downloaded on 13 November 2023

Terms of Reference	MHCN Submission
iv. existing employment standards;	No comment
v. the role and scope of workforce accreditation and registration;	No comment
vi. the skill mix, distribution and scope of practice of the health workforce;	No comment
vii. the use of locums, Visiting Medical Officers, agency staff and other temporary staff arrangements;	No comment
viii. the relationship between NSW Health agencies and medical practitioners;	No comment
ix. opportunities for an expanded scope of practice for paramedics, community and allied health workers, nurses and/or midwives;	No comment
x. the role of multi-disciplinary community health services in meeting current and future demand and reducing pressure on the hospital system;	No comment

Terms of Reference	MHCN Submission
xi. opportunities and quality of care outcomes in maintaining direct employment arrangements with health workers;	No comment
G. Current education and training programs for specialist clinicians and their sustainability to meet future needs, including:	
i. placements;	No comment
ii. the way training is offered and overseen (including for internationally trained specialists);	No comment
iii. how colleges support and respond to escalating community demand for services;	No comment
iv. the engagement between medical colleges and local health districts and speciality health networks;	No comment
v. how barriers to workforce expansion can be addressed to increase the supply, accessibility and	No comment

Terms of Reference	MHCN Submission
affordability of specialist clinical services in healthcare workers in NSW;	
H. New models of care and technical and clinical innovations to improve health outcomes for the people of NSW, including but not limited to technical and clinical innovation, changes to scope of practice, workforce innovation, and funding innovation; and	Please see comments above around Peer Workers – item F (i)
I. Any other matter reasonably incidental to a matter referred to in paragraphs A to H, or which the Commissioner believes is relevant to the inquiry.	