



Productivity Commission Inquiry into Mental Health Response to the Draft Report

Lived Experience Australia is the representational organisation for Australian mental health consumers and carers and is the new trading name for the Private Mental Health Consumer Carer Network (Australia) Ltd, formed in 2002. Our core business is to advocate for systemic change, empowerment of consumers and carers in their own care, promoting engagement and inclusion of consumers and carers within system design, planning and evaluation and most importantly, advocating for consumer choice and family and carer inclusion.

We thank the Productivity Commission for providing us with the opportunity to review the Draft Report. We welcome the Recommendations and agree that Australia requires a generational shift in mental health across public, private and the community sectors to ensure a real consumer centred approach, with acknowledgement of the critical role played by families and others.

We agree with the focus of mental health service delivery to be based on a Stepped model of care; but this needs to be coordinated so that consumers do not fall through the gaps, and so that carers and their input to care discussions are not excluded.

We agree with the Draft Report that urgent action is needed, and implementation is required now to:

1. Improve peoples' experiences with mental health care;
2. Expand clinician supported online treatment options; and
3. Ensure services focus on regional need.

Further, we agree that Police and paramedics do well in mental health crises with not much upskilling, but we agree that any training will be useful.

We agree that care coordination is absolutely needed for those with complex and serious presentations, and support one care plan shared between providers ie care coordinators.

Improved ED experiences are a priority and the planned 8 mental health centres will go a long way, once implemented, to ease this pressure. However, peer led alternatives are also strongly recommended.

However, we do not understand the recommendation for the need for child and adolescent mental health beds to be separate to adults. We would expect this is the case now, although we are aware that more funding is urgently required to take referrals of young people who report to headspace sites, for example, needing greater care than can be provided by that service.

National Mental Health and Suicide Prevention Agreements

We believe that this is the cornerstone in bringing Australia's mental health system into a coordinated, accessible, respectful and responsive system which provides consumers and their families with the best mental health and support care in the world. This will provide structural reform, and clarify roles, responsibilities and funding across all governments. Central to this is the engagement and inclusion of consumers and carers who are in the unique position to advise what will best meet their needs rather than focussing on particular programs etc. The community managed system is also under-recognised, and a great deal of mental health support is provided in these settings.

The area which required significant consideration is the private mental health system (which we detail later) and where this sits within systemic reform.

Consumer Centred care

Our Executive Director Janne McMahon attended Mental Health Australia's Grace Groom Oration in November 2019 at which Commissioner Dr Stephen King spoke eloquently about the Inquiry. What came through very clearly was the need to put the consumer at the centre of service delivery, something our organisation has been articulating for a long time. Generally products are trialled or tested before being rolled out yet this does not happen generally within a health system yet the money expended by Governments and health insurers on services could well be targeted in different ways, better meeting the needs of consumers if they were involved right from the planning stage.

Interventions early in life

What is clear is that mental illness first emerges early in life, particularly teenage years and the need to better understand and identify risk factors is crucial to provide the right treatment and support at an early age is required.

We support the mental health screening of children 0-3 coinciding with their physical checks. Children at risk could be identified early, as could children in schools or early learning centres. Those undertaking the checks would be in a position to be alerted to family issues/history and therefore more likely to identify children that may need greater support. We know that young children who are withdrawn, quiet or particularly sensitive need to be particularly supported.

Regarding the recommendation around schools employing a dedicated school wellbeing leader, Lived Experience Australia supports this; however, we would urge further analysis to ensure effective and appropriate appointments.

Holistic care

We agree that the mental health system requires access to other than clinical pathways for consumers including support for carers, and a clear pathway is needed. There is a lot of talk about 'holistic' care, but in practice this can be quite narrow. System navigation is difficult, less so in the public system with all aspects of the stepped care processes being offered, but not in a manner that is conducive to clarity, continuity or coordinated approaches. However, the private system does not allow a full range of services across the stepped care approach, but it does have continuity of provider.

Whilst supporting the recommendation and model of consumer pathways in the mental health system, Lived Experience Australia believes issues such as data sharing between providers, consent and privacy, carer inclusion and rights, follow-up and financial incentives would need to be addressed.

Private mental health sector

We support improved coordination also targeting people receiving services from the private sector.

We would urge the Productivity Commission and federal Government to look at ways in which mental health care funded by health insurers can be improved. We refer to the Improved Models of Care Working Group and the specialised Mental Health Improved Models of Care Subgroup which was formed to identify legislative and other barriers in providing care outside of the hospital environment. Private Psychiatric Hospitals are in an excellent position to provide community-based supports and outreach.

The value of access by consumers with community services provided within or by private psychiatric hospitals is that the hospital is accredited under the National Safety and Quality in Health Care Standards ensuring high quality services, provides the therapeutic alliance with the consumer's

psychiatrist, collects and reports outcome data, undertakes rigorous evaluation of the programs offered and provides direct feedback to the treating private psychiatrist.

We would urge the Commission to engage in further dialogue with private sector entities and our organisation in taking this sector forward.

Community based mental health care

There has been a great deal of dialogue and reports focussed on less inpatient care with many consumers being more suitably supported in the community. It is fair to say that Australia has not invested sufficiently in this area following deinstitutionalisation many years ago.

Gaps have been identified over and over, and whilst there are recommendations in this area in the Draft Report, they seem unclear. In fact, we are seeing a reduction in funding to community managed organisations rather than the increases required. Some of this could be attributed to state and territory funding going to the NDIS but we are seeing consumers not accepted by NDIS and falling through the cracks when the CMOs cannot afford to run the services they had previously.

We agree with the recommendations for greater guarantee of continuity of psychosocial supports and believe this is urgently required, but think further analysis is required to ensure the right organisations are funded appropriately and which ensure accountability.

Trials and pilots

Trials and pilots will be required to enable innovation. At the heart of this will be the consumer and carer voice; in other words, design services to better meet their needs as a first priority. Service planners need to recognise the value of lived experience, that is knowing 'What works, for whom and in what circumstances'.

We note the following text and fully support this approach. We quote the Overview:

The reforms outlined in this draft report provide incentives for key players to work together without relying simply on the goodwill of committed staff. And they present a way for governments to coordinate within, and improve, a mental health system that fails far too many people. Pg 7

The effectiveness of the proposed changes would be amplified, were we also able to reduce stigma, and generate a change in community culture around how mental ill-health is understood and the way we respond to those who experience these difficulties.pg 8

Reduce stigma amongst health professionals

Much of the stigma shown towards consumers/carers is often from health professionals themselves. Perhaps the system wears them down and they become desensitised. Perhaps the volume of people, the issues of insufficient beds or lack of referral pathways disenchant people; we are not sure. We would urge an holistic focus that prompts health professionals to acknowledge the breadth of peoples' needs, strengths and capacities; not focused predominantly on a deficits viewpoint and clinical diagnosis and stereotypes.

We urge Lived Experience Australia's inclusion in any initiatives around stigma reduction either by the federal Government or through the National Mental Health Commission.

MBS Item Number Review

The MBS Review Clinical Committee recommended an alternative suite of MBS item numbers to replace MBS 288. Innovation must be found to provide care to regional, rural and remote communities particularly face to face or via tele or video conferencing.

Currently there is a cost burden to the MBS because consumers seeking psychological care are required to attend a GP for a Mental Health Treatment Plan for physical conditions caused or exacerbated by mental illness.

We urge the Commission to review this issue and recommend that or a physician can refer directly to psychologists for four consultations.

Similarly, we urge the Commission to review a new MBS item offering yearly health checks to people with mental and chronic physical illnesses such as that currently provided for indigenous people 45K+ under MBS item number 715.

Better Access

We also refer to the Draft Report recommendations in regard to the *Better Access* initiative. *Better access* could be better designed to reflect the needs of consumers, ie. mild to moderate could be facilitated by registered psychologists in the first instance, but we also fully support the extension of 10 sessions before a GP review. We also strongly support up to 20 sessions with an endorsed psychologist for those with serious and complex presentations with the endorsement reflecting additional training and supervision.

Peer Workforce

Our organisation undertook an 18-month project to scope the need for a member based national organisation to professionalise the peer workforce. The peer workforce is already established and Lived Experience Australia strongly supports the establishment of this national organisation for both consumer and carer peer workers.

Housing

We fully agree with the need for improved links with housing supports. There are some great examples of care within the mental health system where people are housed for up to 6 months with clinical supervision and a range of adjunctive psychosocial support but have their own units on one site.

We are seeing much of the public housing diminish, with private rentals mostly out of scope for someone on a disability support pension. Furthermore, we are seeing the closure of many of the privately owned community supported accommodation, further diminishing options. We are very concerned about the apparent increase in rates of homelessness. It is certainly more visible in our communities, affecting people in all age groups.

Participation of people in education and work

Having something to occupy time constructively is needed for people with mental illness. One of those things is the ability to work or undertake training and education. Options for part time employment must be encouraged and we support more appropriate job plans being used by employment services.

We also agree with the Draft Report that Universities must have effective strategies to support the mental health and wellbeing of students. They are large organisations large cohorts of younger people, in particular, and therefore provide a prime opportunity to identify and reach people early in regard to their mental health. This requires them to be more inclusive and for greater awareness and skills to support students who may have existing or emerging mental health problems. Disability

Support Officers (DSO) are located in most universities however we understand that there seems to be insufficient DSOs to meet the needs of students with disabilities including students with mental health issues. Further, we understand that some senior staff within universities seem to have little understanding of mental health issues, with support being minimal and provided only as required under the Disability Services Act.

We believe all universities require clear information on their support processes for students requiring assistance with mental health issues. This should include information on the following:

- University system for accessing support
- Crisis telephone numbers: such as Lifeline 13 11 14 and beyondblue 1300 22 4636
- Beyondblue peer to peer online support <https://www.beyondblue.org.au/get-support/online-forums> 24 hours a day, 7 days a week
- Information on mental illnesses such as anxiety, depression, and others from <https://www.beyondblue.org.au/get-support/get-immediate-support>

Indigenous mental health and wellbeing and suicide prevention

Lived Experience Australia supports the recommendations especially supporting the upskilling of indigenous communities around early warning signs, prevention strategies etc. The organisation *Rural and Remote Mental Health*¹ provide first class educational programs to indigenous communities facilitated by indigenous people. We recognise the importance of self-determination and community capacity for having positive impacts on mental health for all people, and particularly for Indigenous populations.

We would ask the Commission to explore the allocation of government funding to support and expand these programs to communities more isolated or those in greater need.

Families and Carers

Lived Experience Australia believes that the Draft Report requires further work in the area of family and carers. We request the Commission review all recommendations through a family and carer lens to ensure that as well as consumers, carers also are at the centre of mental health services.

For far too long, families and carers have been actively excluded from discussions regarding the person they support, with privacy and confidentiality used. Carers have rights and that at the very least should be in a position to be listened to, consulted, provided with information about diagnoses and medication side effects and involved in discharge planning particularly if the consumer is psychosocially challenged and reliant of their hands on support. Carers are often on call 24/7 and are responsible for addressing crises etc with most not having the clinical understanding to do so.

Many carers are disadvantaged because of their carer roles in a number of areas some of which are:

- 1) Their own physical and emotional well being
- 2) Being on call 24/7
- 3) Impact on employment:
 - Increased anxiety because of frequent leave requests
 - Unable to accept promotional opportunities when offered
 - Less productive because of stress levels and anxiety
 - Restricted work hours
 - Unable to work full time
- 4) Effects on their social life
- 5) Isolation
- 6) Development of their own mental health issues
- 7) Chronic tiredness
- 8) Difficulties with the qualification for the carer allowance/carer benefit

The April 2009 *Who Cares ...?*² Report on the inquiry into better support for carers, House of Representatives Standing Committee on Family, Community, Housing and Youth contained 50

¹ Website: <https://www.rrmh.com.au/>

²

https://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=fchy/carers/report.htm

recommendations. A very high number of these recommendations are still outstanding; many of which address many of the issues raised herein, despite that report being a decade ago.

We would ask the Commission to review the recommendations within this landmark Report to ensure the recommendations are included within the re-design of the mental health system.

Carer Allowance and Carer Payment Forms

In terms of assessment and the form itself, it has a strong focus on physical disability, for example Page 4 has 10 questions, 8 of which relate to physical functioning.

Despite chronic psychosocial disability, there are times when a crisis or acute phase of an illness occurs which renders the consumer completely dependent upon their carer. At these times the consumer is quite dysfunctional and would need assistance in all things included above ie toilet use, feeding, mobility, dressing and bathing for example, but not all of the time. Psychosocial disability is a permanent condition which results in functional impairment but also within this condition are recurring episodes of mental health illness. The signs and symptoms of their mental illness may vary over a considerable length of time however account must be taken into consideration of the severity, duration and frequency of the episodes. Lived Experience Australia does not believe that this situation is fully understood and certainly the assessment process and the Medical Report Form does not adequately address this issue as it relates more to whole of life.

Suicidal ideation

Consideration must also be given to a criterion for people who are experiencing long term suicidal ideation or risks of self-harm. This sees carers being required to ensure the person they are caring for is not left alone at any time as 'they' have raised with the carer their concerns of feeling unsafe all of the time. The carer is unable to leave them to ensure their safety which for many carers, means not being able to go to work.

Drug and Alcohol Use

There is no specific criterion for assessment or within the Medical Report Form which takes into consideration the existence or co-morbidity of drug and alcohol use. For many people who are affected by long term chronic drug and alcohol use, they too neglect most aspects of self-care. The person finds it difficult to hold down employment, housing etc and many find themselves with intermittent homelessness, which is a reflection of the needs of carers in these circumstances.

We would ask that there is a recommendation to review of the Carer Allowance form; again something which has been highlighted in many submissions from our organisation. Work started on this review by the Department of Social Services, but Lived Experience Australia is unable to ascertain whether this has finalised.

In concluding, Lived Experience Australia, as the representative organisation for mental health consumers and carers, would be keen to be involved in any discussions going forward. We are in a unique position to provide expert advice based on lived experience of mental health issues. Please contact me on the following:

Janne McMahon OAM
Chair and Executive Director,
22 January 2020