

SUBMISSION: Productivity Commission Inquiry

“The Social and Economic Benefits of Improving Mental Health” January 2020

**BrainStorm Mid North Coast** is a non-profit consumer and carer advocacy group based in Coffs Harbour, NSW. Membership is people with a lived experience, carers and family of people with a mental health condition. We provide emergency food packs, toiletry packs and host fortnightly morning teas in the Mental Health Unit at Coffs Harbour Base Hospital. We are currently engaged in service mapping of our district with the aim of establishing a mental health community hub in Coffs Harbour. We also provide input from a consumer and carer perspective into reviews or consultations. BrainStorm Mid North Coast is committed to improving service delivery and mental health outcomes in the Mid North Coast Region.

BrainStorm Mid North Coast supports the vast majority of recommendations in the Draft Report. Our comments are in relation to a few issues we feel could benefit from more detail or consumer/carer input. All page references are to the Productivity Commission Draft Reports (Overview, Vol 1 or Vol 2). The Draft Reports are a valuable resource, and we commend the Commission for providing such a thorough and well balanced overview of mental health services and policy. However, it is expensive to purchase for smaller non-profit groups. We would promote the allocation of a small number of copies of the Final Report to be available free of charge to non-profit community groups working in the mental health area, if they have made a submission and have limited funds.

### **One Parent Families**

1. The bar graph (Vol 1:5) of household characteristics of people with a mental illness shows that one parent families with children are the largest group represented (over 30%). This is not reflected in the body of the draft report, except as part of the “Social Inclusion” reform objective where single parents are referred to as more likely to suffer from social exclusion and poor mental health (Overview:93). There is a necessity for more concrete recommendations in relation to single parent households, and for links between sole parent families and children/youth mental health to be explicitly recognised and elaborated on.

2. There is a clear link between sole parent’s mental health and children’s mental health. Children raised in sole parent households are significantly more likely to be exposed to all of the risk factors associated with developing mental health conditions. This includes socio-economic disadvantage (which can be directly linked to poor physical health), personal trauma (including the breaking up of the family unit, disjointed care arrangements with primary caregivers, potential exposure to domestic violence, substance abuse or mental illness within the family unit), instability in housing, and being in the child protection system (Vol 2:661).

3. Children within sole parent families are therefore more vulnerable to poor outcomes in physical, social and emotional health and face multiple risk factors (Vol 2:662). Both parents and children within sole parent family units therefore need to be considered a significant group of the population who merit special measures when developing mental health prevention and support programs.

4. We reiterate the point made in our previous submission – “14. We would like to see greater support for sole parents with mental health conditions and less incidences of formal intervention/removal from care of children. This can have a devastating impact on both parent and child and *could be prevented with greater support at the community level and access to respite.*” Respite services could be similar to that currently offered to carers. Developing specific measures targeted at these family units is therefore strongly supported, and we believe one parent family

units need to be recognised and identified as one priority for practical support and assistance in treating and preventing mental ill health.

### **Online Treatment**

5. Online treatment options should be integrated and potentially expanded, subject to some considerations. The suggested timeframe of 5-10 years for review of these services (draft recommendation 6.1) may not be suitable considering the rapidly changing nature of technology and the cost of investment in expansion. The online treatment and monitoring industry for mental health is a huge and fast growing area. The current online treatment options offered should be mapped and independently evaluated prior to further investment. This ensures services match current and emerging needs.

6. Existing services may need to be promoted or modified, rather than developing new ones or expanding existing ones. Online delivery of psychological and psychiatric consultations (draft recommendations 5.7, 7.2) and CALD services (overview:56) as well as clinician supported services may be exceptions to this. Funding priorities need to be carefully weighed up and directed to the expansion of most in need services (for example, community based infrastructure/hubs), and not necessarily the expansion of online services without thorough evaluation and review of the current situation.

7. In addition, consumer assistance phone lines (draft recommendation 10.1) may have greater benefit in some circumstances and online treatment options need to be co-ordinated with these services. We agree that the "Head to Health" portal is the best site to coordinate online and telephone services and should be expanded and promoted. Current telephone services address crisis (lifeline) and children/youth (kidsline) but there is a gap in telephone support for people with mild/moderate mental illnesses in the adult category, and carers/support persons.

8. Draft recommendations 6.2 and 10.1 that the Government instigate awareness campaigns of online therapy services that are already available and the Head to Health portal are very important, as recognition by consumers of the different online services available is widely variable, and online service delivery appears fragmented. While there may be evidence that some consumers are more likely to remain motivated to use such services if there is a fee (Vol 1:267), in the interests of access and equity, Government provided online services can be considered a public good and should remain free.

9. There is also an equity issue in relation to access to technology, data/wifi and there is a risk that some of the most vulnerable consumers with highest need have financial, technical and literacy barriers to using online services. This is another reason why telephone services should operate in tandem with online services, and be co-ordinated to address service gaps.

10. We support the development of a regional online navigation platform (draft recommendation 10.2) for mental health services, based on the HealthPathways portal currently used by most PHNs, which incorporates the ability to book consultations with service providers. We would like to see the range of services contained within the portal to be expanded to include for example – emergency accommodation services, subsidised food outlets (food banks), welfare services, public transport routes, education and training/employment agencies, locations of pharmacies and bulk billing medical clinics, support groups, and rebates available from state and national governments for utilities and services.

11. There is therefore scope for this regional portal to provide information to mental health consumers beyond mental health services, and to link consumers with a range of social services that can support and enhance their mental health by reducing financial stress, and making it clear and easy to navigate the range of clinical, allied health, psychosocial and welfare services available at a regional level.

### **Digital Records**

12. While “expanding the use of digital records in the mental health care system would facilitate greater information sharing” we are not convinced it would necessarily “improve consumer experience” (overview:66) across the board. The use of mental e-health records needs careful balance between clinician and consumer needs.

13. The proposal that “existing digital health record systems, such as My Health Record, can provide an adequate platform for information sharing between providers of mental healthcare services” (overview:66) is clear, but some modifications may be needed to address consumer concerns regarding privacy, data retention and third party access to information, amongst other issues. Mental health records present different concerns around privacy and so on than physical health records, which necessitates some distinctions in the implementation of e-health records.

14. Before this approach is adopted, extensive consultation with mental health consumers is needed. Our preferred approach is 1) that a digital mental health record is not fully integrated within the My Health Record and 2) any introduction of mental e-health records are “opt in” and not “opt out” (as the My Health Record was). Instead, more flexibility to meet different consumer needs and preferences may be required. One approach could be to have the mental e-health record as an independent component within the existing e-health record system.

15. This proposal would mean that My Health Record remains centred on physical health, and a sub component of that is another record for mental health, which the consumer controls linkage over. So the ability to link or de-link these records remains within consumer discretion. This approach would mean that it is possible for the consumer to choose a) to have the mental health component of the record available only to mental health clinicians (and an optional nominated support person) or b) to have both the mental health record and the physical health record available to all treating clinicians, with a mechanism to adjust the linking of the records depending on current circumstances or needs.

16. It is essential that any digital record for mental health can be de-activated by the consumer. If it is de-activated, it may be able to remain in “read-only” mode, which may either be accessed only by the consumer, or if the consumer gives permission, treating mental and/or physical health clinicians. The option to re-activate it could then be utilised if needed, which may be particularly relevant for those who suffer from episodic conditions. However, as mentioned, this recommendation would require extensive consumer input and consultation in a manner which clearly explains the positive and negative implications of creating and maintaining a mental e-health record, including data retention requirements and the scope of information sharing between service providers.

### **Single Care Plans**

17. We support the use of single care plans (draft recommendation 10.3), subject to the above considerations. That is, that it is “opt in” by the consumer and that suitable protocols are developed in close consultation with consumers regarding information sharing between service providers. The use of care co-ordinators to oversee these plans is supported.

### **Peer Workers**

18. The expansion of peer support workers is a very positive recommendation, as they offer unique insight into self-management as well as navigation of the myriad of services available. They provide guidance with compassion, dignity and hope, and give faith in future wellbeing – which is vital for recovery. The ability and capacity of peer workers to play a role in mental health management and care is currently underestimated and underutilised.

### **Police Education and Training**

19. As part of a general stigma reduction approach, we support more education and training about mental illness for Police. This is important given that people with a mental illness are over-represented in every part of the justice system (overview:33). This education and training should be regularly undertaken, and not just once as part of initial training. The appropriate use of force, methods to de-escalate situations, and effective communication with people suffering from mental health conditions could be aspects covered. We would like to see a specific recommendation on education and training related to mental illness (potentially delivered by those with lived experience/consumers) for Police and staff within the justice system.

### **Traditional Healers**

20. Draft recommendation 20.3 recognises that *traditional healers have the potential to help improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people*. We would like this concept extended further to include culturally and linguistically diverse communities. Traditional healing modalities from other cultural groups have a strong role in maintaining wellbeing, and have been used for thousands of years within those communities.

21. Some of these cultural groups are very large in Australia and merit equal consideration alongside ATSI, such as Chinese and Indian communities. We see no reason to include only one type of traditional medicine in this recommendation, given the cultural diversity of Australia. There are multiple forms of traditional medicine presently operating in the health care sector, that serve a variety of very well established cultural communities within our multi-cultural landscape.

22. We strongly advocate the extension of “traditional healers” to include those that relate to other cultural groups that exist within Australia such as Chinese communities (TCM - Traditional Chinese Medicine) and Indian communities (Ayurveda). We therefore recommend that the evaluation for best practises for partnerships between traditional healers and mainstream mental health services (overview:96) be extended to incorporate TCM and Ayurveda, and potentially any other major traditional healing techniques identified that are specific to any significant cultural group in Australia.

23. There is scope for these treatment modalities to improve the wellbeing of people outside the boundaries of the specific cultural group they have originated in. Access to any services that develop from this evaluation should be open to anyone and not restricted to people only of that respective cultural background (or that identify with that cultural background). Services that develop from this evaluation may not only be more culturally appropriate, but also be more cost effective, and have potentially higher impact on mental wellbeing than existing services. They also offer a way to extend the infrastructure of mental health services available without significant additional cost.

24. Frameworks identifying the range of practices that can safely and quickly be incorporated from traditional medicines should be undertaken by medical anthropologists, experts in public health focussing on indigenous medicines, and through intensive consultation with the relevant communities and consumer groups within those communities.

25. We emphasise our support for this recommendation (as extended to CALD groups), and strongly believe it has a severely underestimated potential in the delivery of mental health services that have higher impact, better outcomes and lower costs. It also potentially removes one of the cultural barriers to improving mental health and wellbeing (overview:13) and aligns with the reform objective to reorient health services to consumers in a culturally appropriate way (overview:52). Traditional medical practitioners may also have a potential role as “low intensity therapy coaches” (overview:58).

26. The capacity and coverage of mental health service infrastructure can be quickly and cheaply increased with linkages to traditional medical systems, as long as there are sufficient economic incentives which may include looking at how to sensitively incorporate these forms of medicine/healing into the Better Access Program and MBS. We fear that this recommendation, which has great merit, may not gain traction without strong political commitment and direction at the national level, and objective analysis that recognises barriers to implementation such as sectional interests.

### **Consumer representatives**

27. Consumer representatives involved in policy/program/project development should receive adequate remuneration, and be provided with induction and training. This is currently not always the case. There may be potential to explore the development of online training modules that can introduce consumer representatives to the structure of mental health care services at the regional, state or national level, and provide guidance on matters like meeting procedures, terminology, government processes and key policy documents. It could also be a central place to list available consumer representative positions. This could be part of the Head to Health portal, or linked from it.

28. Consumer Representatives also need to be able to speak openly and without fear of retribution or termination of their position. They lack the normal safeguards and services associated with paid employment and there is ambiguity around the tenure of their position - this isn't conducive to frank advocacy. A single contact point for all consumer representatives, who can impartially address any concerns or queries, and mediate and problems, could be useful.

29. While the concept of consumer representatives has merit, a lot of work is still required in order to ensure these positions are filled by suitably trained and remunerated people who have access to support in the event of any problems they encounter in the course of their activities. Consumers should be involved in the complete policy or programme cycle, from co-design of concepts through to evaluation. However, these are still often simply tokenistic positions, with little actual substantive input made in policy and programme development. We hope this changes in the coming years, as consumers have valuable insight into practical ways to improve service delivery – if genuinely listened to and engaged with in an equal partnership. Even negative and critical input is valuable, and agencies shouldn't selectively filter input in order to support their preferred positions or existing services. A significant cultural change is required to achieve the full benefit from consumer input.

## **Community Hubs**

30. We would appreciate more information and emphasis on Community Hubs in the Final Report, as such centres can play a pivotal role in matching consumers with the right level of care, as well as providing information on self-management; local mental health, allied health and social services; online access and online service information; and peer support. Stigma reduction is also a vital role of Community Hubs.

31. If the Commission can provide any information on the current locations of community hubs in Australia, how they are funded and any evaluations of their operations it would be beneficial. We think a much greater role could be given to Community Centres, as they can co-ordinate information on many clinical and social services relevant to their communities and offer a safe space for consumers to interact and engage with support workers and each other. The face-to-face contact offered by a Community Hub is also therapeutic and valuable to those experiencing isolation and exclusion, crisis or lack of family support.

## **Income Support**

32. The Commission states that the income support system “would ideally enable people with episodic mental illness to flexibly transition on and off income support as their functional capacity to earn income changes with their health” (overview:39). We agree that this would be the ideal scenario. However, many people with mental illness were assessed under the previous impairment table, and if they enter the workforce and lose eligibility for the DSP, are unlikely to regain it under the new impairment table, if they cannot cope with the demands of the employment or have a relapse of their condition.

33. If those people with mental illness who obtained the DSP under the previous impairment table could be grandfathered under those provisions, it may encourage more to return to the workforce with the knowledge that if they need to access income support in the future they will remain eligible. The current impairment table and assessment tools for all forms of income support also need to be modified to better accommodate psychiatric disabilities.

34. We support the raising of the income threshold at which DSP recipients begin to lose their benefits, and would like to see a stronger position on the adequacy of current income support measures considering the significant out of pocket expenses incurred by many of those with mental health conditions.

## **Conclusion**

Thank you for the opportunity to participate in this Inquiry, and for giving weight to the consumer voice in the process. We look forward to the Final Report and hope that the recommendations made to improve service delivery and mental health outcomes come to fruition.

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