

SUBMISSION: Productivity Commission Inquiry

“The Social and Economic Benefits of Improving Mental Health” April 2019

BrainStorm Mid North Coast welcomes a review into the benefits of improving mental health in Australia. BrainStorm MNC is a non-profit consumer advocacy group based in Coffs Harbour. Our members are people with a lived experience, carers and family of people with a mental health condition. We provide emergency food packs, toiletry packs and host art therapy sessions and fortnightly morning teas in the Mental Health Unit at Coffs Harbour Base Hospital. 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.

We commend the Productivity Commission for producing such a comprehensive and concise issues paper which presents an overview of the current status in relation to population mental health and wellbeing, as well as service delivery and related matters such as employment and housing. This issues paper is an extremely valuable resource in an area of social policy which is very complex, and in which the literature is vast and at times confusing and overwhelming.

Our specific comments in relation to the scope of the Inquiry are:

1. The paramount priority of any Government should be to improve population mental health as an end in itself, and not as a means to improve productivity and economic growth. While the latter is also an important objective, it should not override the social, emotional, and personal benefits of improved mental health. Enhancing economic growth is a flow on effect of maximising wellbeing and should not be the primary objective of mental health policy.
2. In line with this, mental health should not be framed as an economic burden/cost and people with mental health conditions viewed as not participating productively in the workforce. It is demeaning for those living with mental health conditions to be viewed as a cost burden and for the Government to frame this issue as an economic policy issue and not a social policy issue. While they are related and interlinked in a complex way, presenting people suffering from these conditions as primarily a resource burden perpetuates stereotypes and myths, and contributes to stigma.

We welcome the recognition of a need to develop a measure to assess the intangible effects of mental illness (Issues Paper 2019:08) and hope that this could be used instead of monetary values and economic terms.

3. People with mental health conditions may reach their full potential, to their capacity, outside of paid employment and find meaning and purpose in a range of activities while not being part of the workforce. Working and earning income shouldn't be used as a yardstick to measure contribution to the community. In some cases, the working environment and responsibilities may be detrimental to mental health and contribute to developing mental ill health and exacerbate existing conditions.
4. Structural weaknesses identified in past reviews (issues paper 2019:12) need to be emphasised as directly affecting the quality of care received by people with mental health conditions, especially in regional and remote areas. This is compounded by socio-economic factors that often affect people disadvantaged by poor mental health such as low income, lack of transport, poor diet, homelessness or instability in housing, substance abuse and lack of support/isolation.

It is a positive development that funding has been redirected to primary care and a “stepped model” although it is too soon to see if these reforms have improved the quality of care at the community level. From a consumer perspective, these reforms have yet to deliver any practical or actual change in services, at least in our region. Issues such as a lack of community level programs, inequitable access to care, difficulty obtaining suitable referrals to practitioners and affordability of services are still present. Rolling out these reforms has therefore made little tangible change to date, to previously identified problems with service delivery. We are aware these reforms are in early stages and are optimistic that they will serve to enable people with mental health conditions to access affordable services quickly and according to need in the future. Currently, it is still very difficult and very expensive to get mental health care services when needed and to maintain continuity of care.

We endorse the concept of community hubs as trialled in some locations such as Grafton and would like to see these types of centres expanded. Peer support workers in outreach positions also need to be drastically increased. The wider use of home treatment teams (perhaps as part of the Dr on Duty scheme), and greater access to case management support is recommended.

5. The question as to why past reforms have had limited effectiveness to address structural weaknesses in health care may be partly related to the emphasis on acute/crisis and tertiary level care with resources limited to biomedical interventions. Other systems of medicine and health care may be better suited to address mental health issues, both mild and chronic. Complementary and alternative systems of health care have much to offer in improvements to wellbeing, and were identified by the World Health Organisation (Alma Ata 1978) as being able to contribute to developing an effective primary health care network.

We would like to see innovation in the use of complementary and alternative medicine to address mental health conditions within the formal health care system, and availability to these forms of care increased. This can include massage, yoga, aromatherapy, dieticians/nutritionists, acupuncture, and a range of other therapies. These may be more cost effective and produce better outcomes than a reliance on biomedical interventions. Subsidised alternative and complementary services for those with mental health conditions would be useful. There is large body of literature available which demonstrates such forms of care are often more beneficial as well as more cost effective than biomedical interventions, particularly for certain mental health conditions such as depression, anxiety, stress amongst others.

One barrier to effective reform can therefore be considered to be sectional interests and the structural dominance of biomedicine within formal health care systems, which is not the most effective way to treat or manage many mental health conditions. A continuing sole reliance on biomedicine will be resource intensive and ineffective in achieving improved mental health outcomes in the longer term.

6. Additionally, reforms have failed to genuinely take into account input from those with a lived experience of mental illness. Tokenism and shallow consultation which only pays lip service to consumers is unfortunately still widespread. This includes highly selective filtering of feedback to incorporate only that which is positive about existing service delivery, choosing consumer “representatives” in advisory groups who are compliant, and failing to consult broadly in preference to small networks of established and entrenched consumer voices.

7. The recent reforms do not adequately address cost of services, shortage of mental health professionals within the public health care system, and the administration of the PBS. Regarding the PBS, the current operation of the safety net used for medication needs to be reviewed and reformed in a way which is more user friendly, simpler to apply and preferably automated at the point of

supply. This is difficult and stressful to manage by an individual, especially when unwell, and can lead to financial loss which could be averted with computerisation. This would improve efficiency and effectiveness of this scheme and reduce the burden of monitoring by an individual.

8. Health workforce shortages in regional and remote areas may be partly addressed by tele-health initiatives, however access to technology needs to be considered as a potential barrier to uptake. Low income earners may not have sufficient hardware or internet access to benefit. Subsidisation and costs of these services is also a matter that needs to be addressed. We do not believe that tele-health is a substitute for face to face services with a health care professional. Tele-health services may offer an adjunct to physical services but not a replacement.

9. The use of electronic health records for mental illness poses many concerns and we do not believe e-health records should be compulsory or phased in as a necessary part of the stepped care model (as indicated in Issues Paper 2019:13 Figure 5). Some of these concerns include privacy, data retention and confidentiality. The use of e-health records needs to be matter of individual choice, and not implemented without consent by the service provider.

10. Changes to the way that informal carers are supported could include greater provision of respite services, access to mediation and counsellors, and an information hub that can provide guidance on the caring role and support services available. A community hub approach as mentioned previously may serve carers as well as consumers and their families.

11. Income support measures for carers and those with mental illness are currently insufficient. Those who do not qualify for the DSP under the points system are reliant on Newstart which creates undue financial stress. The method for assessing mental illness for the DSP requires modification to prevent those who are unable to participate in the workforce falling into a cycle of poverty, homelessness and poor physical and mental health. The mechanism for assessing work capacity needs adjustment particularly for episodic conditions. Training and subsidised placements for those with mental health conditions to participate in the workforce needs to be increased.

12. We do not believe there is evidence to indicate that income support payments for those with a mental illness reduce the propensity of recipients to seek employment. Instead, this is a very restrictive and meagre safety net that some people need in light of their limited capacity to work. The vast majority of people with mental health conditions seek to work, and would value both the income as well as the opportunity to engage socially and develop skills or utilise their qualifications. However current workplace practices are generally not flexible enough to accommodate episodic conditions or the specific nature of some mental illnesses.

Introducing measures to accommodate mental ill health such as flexible working hours, ability to work from home, job sharing and extended sick leave provisions could assist more people remaining in or returning to paid employment. There may need to be incentives for businesses and industry to adopt these measures more widely than they currently exist.

13. Social participation and inclusion programs are currently weak or non-existent in our region. Community hubs could be used to improve social inclusion. Subsidised placements in a broader range of education and training courses would also enhance both inclusion and employment prospects. Social inclusion programs need to be viewed as an investment and not a cost.

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.

15. In terms of people with a mental health condition and contact with the justice system, we advocate for the automatic removal of some information (photographs, finger prints) from the Police Record System if an incident is dismissed under section 32 of the Mental Health Act. Currently people need to apply to the Police Commissioner to have this data removed.

Further training for Police in mental health conditions and dealing with people who have mental health conditions is warranted. Discrimination and bias still exists, based on poor understanding of these conditions. It is traumatic for people with mental health conditions to have contact with the justice system and more sensitivity and compassion is needed.

Thank you for the opportunity to participate in this Inquiry and we look forward to reading other submissions, and the reports produced. Mental health and mental health care services urgently need restructuring, and funding needs to be redirected to community level primary health care which is easy and affordable to access. It is not just about funding, it is about co-ordinating the services that exist, to enable those with psycho-social disabilities to navigate the system with dignity and hope.

Yours sincerely

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Chair

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