SUBMISSION TO THE DRAFT MENTAL HEALTH PRODUCTIVITY COMMISSION REPORT 2019

[redacted]

I live in Wagga Wagga, NSWs largest inland city, with a population of 60,000 but a catchment area of 200,000.

I have read the first volume of the draft report and am aghast at many of its recommendations for the following reasons:

- The profound and unforgiveable lack of research that has been carried out about mental health services available to those with mental illness in regional and rural areas;
- The discrimination demonstrated towards those suffering mental illness in regional and rural areas;
- The extreme naivety and ignorance (at best) but really, the *complete lack of empathy you have demonstrated* in making these recommendations as they apply to consumers with mental illness in regional and rural areas.

Your section: 'Living in Regional and Rural Areas' p. 165 is woefully inadequate taking up only a third to a half of one page of text in a report of more than 900 pages. You appear to have conducted hardly any research at all about the services provided here and the colour-coded map you provide suggests Wagga Wagga receives only 2% fewer of the population being able to access mental health services than in the city, which is a completely false statistic.

In particular, I am completely dismayed, actually quite horror-struck, that you are planning to remove item no. 288 from the Medicare schedule for telehealth conferences between psychiatrists in the city and consumers in regional and rural areas.

On p. 59 of the report you state:

DRAFT RECOMMENDATION 7.2 — PSYCHIATRY CONSULTATIONS BY VIDEOCONFERENCE

In the short term (in the next 2 years)

- The Australian Government should introduce a new suite of time-tiered items for videoconference consultations to regional and remote areas (RA2–5), as recommended by the MBS Review Psychiatry Clinical Committee, removing item 288 from the MBS.
- In addition, the Australian Government should add new items for videoconference consultations mirroring existing items for psychiatric assessments (item 291) and reviews (item 293), that are available in major cities (RA1) as well as in regional and remote areas (RA2–5), and that are paid at the same rate as items 291 and 293.

I want to outline the effect this decision will have on me personally and then other residents in Wagga.

I regularly see a psychiatrist based in Melbourne via teleconference who charges my consultations using item no. 288 from the MBS. As mentioned previously, I have a complex array of mental illnesses and am on

multiple medications. I need to see her regularly for frequent adjustments to my medication, because of the complexities the medications I am on and potential interactions, frequent changes in my mental state (including suicidality) and the provision of regular scripts. This is particularly important as my GP does not feel comfortable writing some of these scripts because they are for medications that are not commonly prescribed. She does not want to take responsibility for writing them.

The service my psychiatrist provides to me under item no. 288 is an essential part of managing my mental illness and a huge help to me financially as my medication bill is so significant. [redacted] I have to pay for these as well as several medications that are not on the PBS.

I am **absolutely distraught** that you are planning to remove this item number from the Medicare schedule. [redacted]

My psychiatrist and I have built up a close rapport over five years. She has learned to recognise my different moods, how ill I am, when I need intervention and what is required in terms of treatment. She understands my sensitivity to medications and the ramifications of coming off them too quickly. Finding a replacement who has her level of expertise, and the crucial implications of the relationship that we have developed over the years is absolutely impossible in Wagga. [redacted]

By removing this item number, you are going to be negatively affecting the mental health status of *numerous* consumers with mental illness in regional and rural areas in an extremely profound way. I am not understating the situation by saying you can expect there will be a direct relationship with removing this item no. and increased suicides throughout country Australia. This scheme has provided invaluable help to mental health consumers in regional and rural patients who have no other access to a psychiatrist.

[The report goes on to say: (p. 300)

However, the Committee also recommended that the MBS Review Taskforce 'should consider recommending an incentive payment, or another similar funding mechanism be instituted, to continue to stimulate services in regional and remote areas'. **However, the need for such an incentive has not been demonstrated.**

I want to ask; ***how*** *has it not been demonstrated*? *Have you researched the demographic receiving these services and their incomes? Have communities in regional and rural Australia recently been given an injection of cash from State and Federal Governments providing extra services to meet the needs of those in their communities suffering mental illness that will breach the huge gap taking this item number away will create*?]

Further, Black Dog provides an invaluable service to our community using telehealth to treat consumers with mental illness as well. Patients are linked up with a psychiatrist from Sydney (after an initial assessment at the institute for a diagnosis) and go to their GP clinics to see their psychiatrist regularly for a telehealth consultation. If item no. 288 is removed these patients won't be able to continue seeing their

psychiatrist. I have personally seen the immense benefit this scheme has brought to our community with specialist advice they have received and the regular follow-up *literally changing people's lives*. Are you going to remove this from us too?

I am now going to go through the report and explain my objections to some of the recommendations that have been made and how they utterly fail to take into account the nature of the provisions that are operating to treat people with mental illness here. To do this I am going to paint a picture of the services we have operating in Wagga Wagga

A PICTURE OF COMMUNITY SERVICES AVAILABLE FOR RESIDENTS OF WAGGA ITS CATCHMENT AREA SUFFERING MENTAL ILLNESS

You say on p.205 that 'People with mental-ill health usually go to their GP first.' In Wagga that is not necessarily the case and it all comes down to money.

[redacted]

GP Services in Wagga Wagga

There are about a dozen GP clinics operating in Wagga Wagga but only one is a bulk billing clinic. In order for this clinic to be financially viable, all sessions are kept as close as possible to fifteen minutes. This is where low-income earners in Wagga go for medical treatment and even moderate earners whose budgets are stretched. People attending this clinic are receiving sub-par treatment for their mental illness and they are often those with the most severe mental illness in our community.

The gap payment sought at the other clinics is often more than a budget can stretch for people in the country suffering drought and its knock-on effects, the ramifications of the profound lack of low-rent housing here, high mortgage payments, the costs of raising children and so on.

We also have an After Hours Clinic for emergencies with consultations ranging from $76–$108 but people tend to go to ED rather than go there.

In your report (p. 177) you concede that:

Consumers can face sizable out-of-pocket costs

Consumers accessing treatment for mental ill-health can face sizable out-of-pocket costs. These can represent the full cost of a service or a shared payment, over and above any amount paid by the Australian Government (via Medicare) or a private health insurance fund (AIHW 2018g)

You go on to say:

Data on the out-of-pocket costs of consumers of mental healthcare is limited. Based on administrative data, out-of-pocket costs for consultations and medication (that had an associated government subsidy) for people with mental ill-health was $700 million in 2018-19. Co-payments in addition to Medicare Benefits Schedule and Pharmaceutical Benefits Scheme are just two possible sources of out-of-pocket costs. **The Commission is seeking more information on out-of-pocket costs.**

Why hasn't this research been done for the report? To so something like remove item no. 288, surely you should have invested time in researching these out-of-pocket costs, particularly in regional and rural areas where there are some very different and serious factors affecting incomes than in the city. For example, (as you mention) 'the cost of travelling to and appointments' for people in outlying areas and the demographics of country areas—average incomes in regional and rural areas. How are you expecting those who have been receiving treatment via item no. 288 to now pay for this treatment? Do you have evidence that our incomes have increased? That we comprise a wealthy demographic? Have you analysed how many of us are on the DSP or possess health care cards? Have you done studies that demonstrate what is going to happen to those who won't be able to pay for their treatment once the item no. 288 is removed? I have spoken to a psychiatrist who provides telehealth conferences to those in North-East Victoria. He has visited the community to investigate the mental services available there on the ground and he has told me that the outcome is going to be nothing less than 'tragic'.

Our GPs are largely not specialised in mental health and those who are (there are only a handful) have full books. Even those GPs who are not experienced in mental health but regarded as being good quality GPs have full books or require consumers booking their appointments weeks or months ahead. You can't expect to ring up on the day and get an appointment in a day or two with one of these GPs. Instead you have to see a registrar or an overseas-trained GP on a Visa with poor English skills and inadequate training and experience. At the practice I attend, these GPs only stay for a number of months then leave and another new batch arrive. The number of people experiencing mental illness of all different kinds is of epidemic proportions in Wagga and quality GP care is only available to the lucky few.

Given that access to quality care from GPs is so restricted, your plans to initiate clinician-supported online therapy for consumers (p.56) and expecting these GPs to somehow have time to develop and progress a single care plan (p. 191) would not work in our city where the majority of those with mental illness attend a clinic where they receive 15 minute appointments and even those GPs who have more time to treat their patients have no other community services to link them in with anyway!

Private Psychiatric Services in Wagga

We have two private psychiatrists (both male) who charge excessively. [redacted] for instance charges $610.20 for an initial appointment and $472 for successive appointment. They are able to do this because there are two of them and they have been able to corner the market. They are only available between 9am–5pm (I can text or email my psychiatrist throughout the entire week if I am in crisis) and neither have admitting rights to our local Mental Health Unit. They are only available to the wealthiest residents in our community. Professionals, retired professionals or their offspring. They can also only treat a limited number of patients (servicing a catchment area of 200,000).

So, your sections on 'Consumer Choice' on p. 240:

Consumer choice

Choice of health provider is valuable to consumers. It has intrinsic value, lets people satisfy their individual preferences (for example, for a provider that bulk bills, or in a particular area) (PC 2017c, chapter 10). Under some circumstances, consumer choice can also drive service improvements (PC 2017c, chapter 10).

Choice is particularly important in the context of therapy, where it can help 'promote a strong therapeutic alliance' between the consumer and the psychological therapist (MBS Review Mental Health Reference Group 2018, p. 22). A strong therapeutic alliance is a key ingredient to effective psychological therapy (Lambert 2013).

And p. 301:

Greater consumer choice can also improve access

Consumer choice can also improve access to psychiatric care and has value to consumers in any case. Giving consumers greater choice of private psychiatrists could help improve the likelihood they would find one with co-payments they can afford, who is available to see them when they need to be seen, and with whom the consumer is able to develop a therapeutic repour (as discussed in chapter 5).

Consumer choice can also improve access to psychiatric care and has value to consumers in any case. Giving consumers greater choice of private psychiatrists could help improve the likelihood they would find one with co-payments they can afford, who is available to see them when they need to be seen, and with whom the consumer is able to develop a therapeutic repour (as discussed in chapter 5).

are totally irrelevant when it comes to regional and rural areas.

PSYCHOLOGICAL SERVICES IN WAGGA

There is a minimum three-month wait to see most psychologists in Wagga Wagga. They also almost exclusively charge a gap on top of the Medicare rebate putting their services out of reach for many with mental illness in Wagga. I saw a psychologist here a couple years ago and she charged me a reduced gap because I was on the DSP. However, I still had to pay an extra $25 each time I saw her, which was a lot out of my DSP budget, [redacted] many choose not to pursue this route because of the gaps charged by these specialists.

THE COMMUNITY HEALTH CENTRE

The only other alternative is The Community Health Centre. However, people with mental illness avoid utilising this service if they possibly can. It offers counselling (with long wait times for follow-up appointments) by undertrained 'counsellors'. There is a three-month wait-time to see a psychiatrist (all are flown in from Sydney). And you don't necessarily see the same psychiatrist the next time they visit so there is limited continuity of care. Those on Clozapine have no choice but to attend the Community Health Centre as this is where the Clozapine Clinic is situated.

THE PUBLIC HOSPITAL MENTAL HEALTH UNIT

Wagga is very fortunate to have a brand-new mental health hospital and the structural facilities are excellent. But appearances are deceptive. There are not nearly enough beds available for those who need them! This is because half the beds are taken up by ice users suffering psychotic episodes or are in withdrawal. (See section below on ice scourge in Wagga.)

People turning up to ED who are genuinely suicidal, or have even made an attempt on their life, are regularly (almost always) sent home with an appointment to see their GP or an appointment to attend the Community Health Centre. *This is an absolute crisis!* Patients may be kept for a short amount of time (up to than 48 hours in ED) but those who have made an attempt on their life will be sent home if they are considered to have a supportive family or carer. This places enormous stress and responsibility on the family/carer to protect their loved one from attempting suicide again when the family/carer can't possibly be expected to have the knowledge or skills about how to do this. *There are regular stories in our local paper of people who have been sent home from ED only to go home and commit suicide.* I find this situation unconscionable.

The unit is also only staffed by different fly-in psychiatrists from Sydney from Mondays–Fridays during the day, so again, no continuity of care. There are no psychiatrists on the ward at night-times or on weekends.

ACCESSLINE

In this part of the state we have a call line called 'Accessline'. It is heavily promoted. But if you ring and say you are suicidal, there is no counselling provided. (Which I think is appalling) They automatically send an

ambulance around to your place to take you to ED and, as I outlined in the previous section, you just get sent home again. Having an ambulance sent around is enormously embarrassing [redacted] It causes enormous stigma for those it happens to, as everyone in the street comes out to have a look at what's happening, and it's a waste of time as you just get sent home again.

If Accessline provided counselling, they might be able to defuse the situation and render a trip in the ambulance to ED unnecessary. I have spoken to so many people about their thoughts regarding Accessline and we've all learned from experience not to bother with them. If people really need go to the hospital, they make their own way there.

COMMUNITY SERVICES IN WAGGA

In Chapter 7 'Specialist Community Mental Health Services' you recommend *as a priority*

- The provision of more community ambulatory services and subacute/non-acute bed-based services, with each region's needs determined by regional service planning.

as a means of keeping people out of acute hospital beds.

Well first of all, as I previously mentioned, we don't have nearly enough acute hospital beds (or non-acute beds) to meet the needs of our town and region and the people who do get admitted only have very short stays anyway so more people can be admitted. So, your rationale here is, again, entirely inapplicable to our region.

In Wagga we have NO community ambulatory services or subacute/non-acute bed-based services at all except Yathong Lodge which is exclusively for those over 65 years of age. *Are you planning to provide special funding to build us some of community ambulatory services*?

On p. 188 the report states:
While there is currently a multitude of mental health services and programs, many gaps remain, particularly for those consumers whose symptoms are not acute enough to require hospitalisation …

Whilst there may be a multitude of mental health services and programs in the city, in Wagga, we only have two community program for consumers. LikeMind and Sunflower House which caters for those with moderate to severe mental illness. However, with the advent of the NDIS, *the Federal Government has, brick by brick, dismantled its funding to zero.*

Sunflower House

Sunflower House has been an institution in Wagga Wagga for many years—it provides club-house type support for those, with moderate, but mainly severe mental illness. It provides a place for people, largely with schizophrenia, to come each day and undertake a thoughtfully put-together program where members work side-by-side learning food preparation, doing art and craft, learning computer skills, tending a vegetable garden, going to the gym and many other activities. However, first:

- One Door closed their Wagga site;
- Then PHaMs was phased out;
- Personal Health and Mentors ceased to exist;
- Then the 'Day to Day Life Program' stopped running;

One Door ran the operation and secured State and Federal funding for it so when they left Wagga, there was a serious shortfall in funding which ran out in April 2019. Sunflower House had been hoping its members would who received the NDIS would be able to pay to attend using their funding, but not all members received the funding (as you know there is a significant cap on those with mental illness who can receive the NDIS) and there was a significant shortfall in the money needed to run the program.

Our local member, Michael McCormack was contacted last year, and he secured a grant of $275,000 but this runs out in June and at this point in time there is no more money to run the program after that. It is hardly ideal for an organization like this to have to constantly try to secure grants to run its operation. This makes planning impossible and uncertainty and anxiety permeate the minds of staff and consumers alike.

Particular Problems Facing Wagga

I'm not sure if any of you reading this watched the 'Struggletown' documentary which aired on SBS last year (it is still on SBS On Demand) but Season 3, episode 1 specifically highlights the particular issues facing one of our suburbs—Ashmont. However, there is actually one suburb faring even worse than Ashmont—Tolland. Both suburbs primarily comprise housing commission houses, have a high proportion of Aboriginal residents *and the suburbs are plagued with an ice epidemic*, resulting in frequent break-ins, burnt-out cars, a surge in domestic violence, armed robberies, terrified residents and severe mental illness amongst the ice users and residents of the two suburbs. Disproportionate police resources are spent policing these two communities. Resources for treating the mental illnesses suffered by these two groups are so inadequate as to be almost laughable.

Conclusion

I would like end by saying that this draft report *actively* discriminates against people with mental illness who live in country areas. It creates a completely unethical and immoral city/country divide. You exercise a type of 'racism' where the mental health of people in the city is valued 50–100 times more than those in the country. Reading the report, you would almost think we didn't actually exist. You're not actually interested in saving people's lives or caring for those with mental illness. You just want to create fancy-sounding recommendations that perhaps look good on paper but towards which little thought has actually been given and even less care or empathy infused. If recommendations such as the removal of item no. 288 are implemented, the result will be utter tragedy in regional and rural Australia.