

## MEDICAL CONSUMERS ASSOCIATION Inc.

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### Productivity Commission Inquiry into Mental Health

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**Submission to Productivity Commission Inquiry**  
into the role of improving mental health to support  
economic participation and enhancing  
productivity and economic growth.

### MCA's Summary Responses to Specific Inquiry Questions

*What suggestions, if any, do you have on the Commission's proposed assessment approach for the inquiry? Please provide any data or other evidence that could be used to inform the assessment.*

MCA has provided a set of pre-readings in January 2019 and attached with this summary a more comprehensive, referenced background paper submission. Bear in mind that MCA is voluntary and un-funded so all this has been written in members' own time with public resources. MCA believes that only by invoking Competition and Consumer legislation provisions, in particular requiring anyone seeking to restrict practices to apply for formal application for authorisation under Sec 88 of the Competition and Consumer Act 2010, can the onus of proof be placed on those making restrictive proposals to justify their positions with data rather than anecdotes and so-called expert committee opinions. That is more than a request – that is the law.

The pre-readings provided by MCA clearly show there is an abundance of “classic” evidence against many of the restrictive claims such as the two- and three-tier treatment hierarchies. MCA does not need to provide 'data' on this as those classic references can be found in any leading textbooks of the past decades. There have never been any newer findings to overturn them and the CCA requires anyone claiming otherwise to present their data and explain why the supposed 'academics' on expert committees have managed to not include these classic references in their own submissions. To have not done so is at the least against the spirit of the law.

*Why have past reform efforts by governments over many years had limited effectiveness in removing the structural weaknesses in healthcare for people with a mental illness? How would you overcome the barriers which governments have faced in implementing effective reforms? What, if any, structural weaknesses in healthcare are not being targeted by the most recent and foreshadowed reforms by governments How should they be addressed and what would be the improvements in population mental health, participation and productivity?*

To posit *structural weaknesses in healthcare* as the problem pre-supposed the answer. The health sector may not be the appropriate place for the sorts of domestic and workplace mental disorders the Inquiry wants to consider for the wider population. As the Inquiry has noted Education, Workplace and Competition & Consumer Law might be more appropriate. Suicide rates go down in some countries and it may have nothing to do with the health sector. It might have more to do with employment or availability of Vodka and guns in the home.

In the past asylums were havens for abuse as persons were incarcerated on flimsy scientific diagnostic systems. Once inside they did not have the usual appeals any criminal accused might expect and possible life sentence without trial. As a result Human Rights Commissioner Burdekin noted that there had been 150 Australian inquiries into mental health. But once asylums were closed creeping “diagnostic inflation” started to conflate the former asylum-level people with “people with a mild or moderate mental illness (such as anxiety and depressive disorders), because they account for the vast majority of Australians with a mental disorder”

The two groups may have nothing in common. Anyone who goes to a dentist is a 'medical consumer' (including dentists themselves) but this does not mean the 'lived experience' of being in a dental chair gives them any common ground as fellow 'pain patients' with someone fighting a psychiatric label in a compensation court case following a back injury from a fall from a ladder. It makes no more sense to lump all alleged 'mental disorders' together and this is what causes many of the problems.

Every one of those 150 inquiries has started from mental illness as a 'given' and proceeded to how we treat the 'sick'. By contrast, the term 'psikhushka' is in common parlance in Russia as they associate it with the use of psychiatric facilities

to incarcerate dissidents. The Australian inquiries are all contaminated by the assumption that everyone who ends up with a psychiatric label was in need of help, or indeed even seeking help. The reality is that the small number of people with the traditional Kraepelinian asylum-level conditions has always been a constant. That some of these might have a 'brain disease' isn't a major issue of contention. Rather, the mental-illness label is cavalierly tossed around and can be used as a weapon against victims of accidents, bullying, workplace and custody disputes. Attempts by the relatives of the Kraepelinian sufferers to 'normalize' mental illness only makes all this labelling more plausible to police, judges, HR officers, politicians and government inquiries.

The problems of the vulnerable incarcerated mentally-ill have more in common with the groups highlighted by the Royal Commission into Institutional Responses to Child Sexual Abuse in residential institutions, out-of-home care, schools, sport, recreation, arts, culture, community and hobby groups, detention environments and religious institutions. Anointing the acute psychiatry end of the spectrum as the mental-health sector default 'experts' distorts the whole picture.

Government fears of opening floodgates of minor life dissatisfactions seeing counsellors at taxpayer expense has also coloured the picture and forced this focus on the acute care needs. They want to only spend money on people with 'genuine mental illnesses'. But thanks to the various lobby groups such as pharmaceutical companies and carers of psychiatric patients the category has bloated out with diagnostic inflation to embrace more and more persons.

#### *QUESTIONS ON SPECIFIC HEALTH CONCERNS*

*Should there be any changes to mental illness prevention and early intervention by healthcare providers? If so, what changes do you propose and to what extent would this reduce the prevalence and/or severity of mental illness? What is the supporting evidence and what would be some of the other benefits and costs? Which forms of mental health promotion are effective in improving population mental health in either the short or longer term? What evidence supports this? What changes do you recommend to healthcare to address the specific issues of suicides and comorbidities among people with a mental illness? What evidence is there to support your suggested actions and what types of improvements would you expect in terms of population mental health, participation and productivity? What healthcare reforms do you propose to address other specific health concerns related to mental ill-health? What is the supporting evidence and what would be some of the benefits and costs? What overseas practices for supporting mental health and reducing suicide and comorbidities should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?*

As discussed more fully in MCAs Pre-reading and Submission papers *early intervention by healthcare providers* can be a dangerous trap. Focus on suicides distorts the entire process by lending a contrived 'urgency' to all the rest. Campaigns such as RUOK, for example, give the impression that the person beside you at the next workstation might be contemplating suicide and that with a quick word you might be able to detect this and prevent it. Psychology texts since 1939 have warned that turning up the supposed sensitivity of assessments to try and predict events such as suicide are doomed by mathematics as they merely turn up huge numbers of 'false positives'.

The Economist opined in 2018 "Why the global suicide rate is falling" <https://www.economist.com/the-economist/why-the-global-suicide-rate-is-falling>. In some places it has less to do with the health care system and more to do with availability of Vodka, guns in the home. and women's employment.

Among the many dangers of 'early intervention' paradigms is commercial exploitation by 'bounty-hunting' of youth to entrap them into psychiatric care. Australia narrowly missed out on this in the 1990s when such abuses were exposed by ABC *Four Corners*. MCA urges great caution in providing any commercial incentives to early-label young people and in particular to start them on a career of prescription drugs for purported and controversial diagnoses such as ADHD, adolescent bipolar disorder and the one becoming popular with young researchers: dissociative disorders.

The evidence-base for the entire edifice of adolescent and child psychiatric medication has come under scrutiny of the US Congress and there is concern in Australian psychiatric circles about this.

We have had a spate of headlines that "Pharmaceuticals officially more of a problem than illicit drugs, report ..." (ABC)

#### *QUESTIONS ON HEALTH WORKFORCE AND INFORMAL CARERS*

*Does the configuration and capabilities of the professional health workforce need to change to improve where and how care is delivered? If so, how should the workforce differ from current arrangements? How would this improve population mental health, participation and productivity? What can be done to address health workforce shortages in regional and remote areas? In which areas or circumstances would greater use of technology and tele-health services be suitable? What prevents greater remote provision of services to address the shortages? What restrictions exist on the scope of practice for different professions, such as GPs, nurses, clinical versus other psychologists, and social workers? Are these restrictions unwarranted and, if so, how could they be addressed and what would be some of the costs and benefits?*

*What could be done to reduce stress and turnover among mental health workers? How could training and continuing professional development be improved for health professionals and peer workers caring for people with a mental illness? What can be done to increase its take up? What changes should be made to how informal carers are supported (other than financially) to carry out their role? What would be some of the benefits and costs, including in terms of the mental health, participation and productivity of informal carers and the people they care for?*

One of the biggest risks to the professional workforce in this sector is from *the concentration of resources in costly acute and crisis care (such as hospital emergency departments), despite evidence that mental health services in community settings can be more effective.* Submissions from the Australian Psychological Society and some psychiatrists have proposed a multi-tiered system in which the more severe cases of mental illness should be referred on to alleged specially-trained so-called 'clinical psychologists' and psychiatrists. The logic is based on the experience of acute crisis teams who might have better outcomes than an individual so-called 'general psychologist' in a suburban shopfront clinic. This is a straw-man argument. Lone practitioners would seldom get referrals from GP's to provide sole treatment to asylum-level severely ill locked-ward patients. Conflating such patients with others on the presumption that every upset person is a 'suicide risk' makes the grand unwarranted assumption that anyone has invented some way of predicting suicide risk.

The multi-tiered propositions have met with a massive backlash from within the APS. If implemented many practices would close overnight. What incentive would there be for a bulk-bill practitioner who had just lost 90% of their referrals as no longer eligible for MBS rebate to somehow be able to stay in practice and act as a free referral agent to their eligible colleagues? To add insult the psychologists raising questions have been publicly mocked as merely 'bickering' and ignoring the needs of patients. The simple answer to this is that if a psychologist is put out of business they no longer have any obligation to people who might have otherwise been their patients. The contract is broken. The registration act would prevent them continuing contact. Waiting lists increase and those few eligible elite can sit in front of tele-health computer screens making hundreds of taxpayers' dollars per hour. The former psychologists now out of work will likely see their previously-eligible potential 'patients' when they join them in the Centrelink queues.

The entire professional edifice in mental health should by law be subjected to formal application for authorisation under Sec 88 of the Competition and Consumer Act 2010. They would have the onus of proof to justify their hierarchies.

Training and continuing professional development is yet another imposition on psychologists and counsellors. It has no scientific basis whatsoever. Psychologists are required to do 30 hours of PD per year, paid for out of their pockets, while lawyers do 10 hours. Law is an ever-changing field. Psychology is not.

As for 'peer workers' and 'informal carers' the current state of affairs can be found on the very websites of the government authorities currently reviewing the mental health sector:

- Productivity Commission Inquiry into Mental Health: *If you need specific help or advice, you can contact one of the services below: Lifeline Australia...*
- Senate Community Affairs References Committee Secretariat: *"Where to get help ... Lifeline ..."*
- Accessibility and quality of mental health services in rural and remote Australia: *"If you or anyone you know needs help you can contact one of the services below: Lifeline ..."*
- Mental Health Commission: *"Get Help ... Lifeline ..."*
- Victorian Royal Commission into Mental Health ... *If you or someone you know might need support, you can talk to a GP or health professional or access immediate support by contacting: – Lifeline:*

Lifeline volunteers are the default 'go to' in Australia. Unpaid persons are already carrying much of this load. And not all of it is altruistic. Many are trapped in the 'provisional registration' cycle, having to put in 3,000 unpaid hours in the hope of one day being registered and eligible for MBS rebates. The onerous and unscientific accreditation examination practices of colleges and accrediting bodies in the health sector has long been a concern of the ACCC. In particular the psychology registration process of AHPRA demonstrably provides no protection or benefit to the public and has never been subjected to ACCC scrutiny. There is overwhelming evidence that much of this is unnecessary. It spawns nothing but navel-gazing cottage industries where psychologists are forced to consult and examine each other instead of providing services to the public.

#### ***QUESTIONS ON HOUSING AND HOMELESSNESS***

*What approaches can governments at all levels and non-government organisations adopt to improve: support for people experiencing mental illness to prevent and respond to homelessness and accommodation instability integration between services for housing, homelessness and mental health housing support for people experiencing mental illness who are discharged from institutions, such as hospitals or correctional facilities flexibility of social housing to respond to the needs of people experiencing mental illness other areas of the housing system to improve mental health outcomes? What evidence can we draw on to assess the efficiency and effectiveness of approaches to housing and homelessness for those with mental ill-health What overseas practices for improving the housing stability of those with*

*mental illness should be considered for Australia? Why Is there formal evidence of the success of these practices, such as an independent evaluation?*

In NSW issues regarding homelessness and mental health started to emerge in the early 1980s when the then Government adopted the recommendations of the Richmond Report. While this seems to be ancient history, our members working in the NSW Health Department at the time recall issues following on closing of the hospitals for people with severe mental health issues and replacing with a series of half-way houses for gradual return to the community. The aim of the then government was to cut costs, but this was unsuccessful as the establishment of half-way houses meant buying real estate at market price and providing services to a smaller group of people in each house. In addition there was strong opposition to half-way houses from the community. These attitudes persist.

Government, it seems is still trying to cut costs. However, the primary factors working against this are the 'normalisation' movement along with diagnostic inflation. Practitioners caught in these ideologies find it increasingly difficult to distinguish serious and debilitating mental health issues from those which do not impact severely on functioning. This risks providing assistance to the more vocal high-functioning people with a mental illness while those in most need are unable to have their need addressed.

Here is the scenario in our country town: A homeless man who has a mild mental illness and has clearly been assaulted overnight sits on the bench in the town square. He is clean, has had breakfast and shows me his new shoes. In our town, the homeless have access to free food, showers in a purpose-built facility, free hair-cuts and new clothes. Everything *except* what they need most: a roof over their head which would protect them from the weather and from thugs who roam the streets and assault them for fun. They are referred from one service to another. Others who camp out by the creek are visited by a local psychologist who conducts her sessions at any time of the day or night outdoors at their camp. Another psychologist is at wits' end because advocates for the rights of people with a mental illness will not assist him to stop his client *eating rocks*. Down the hill in an up-market resort a man who has enough money to pay top rent and is temporarily distressed (has a mental illness) puts a match to a can of petrol and blows up the apartment in a suicide attempt which lands him in hospital with third degree burns.

Government and charities must step in to provide managed shelter and care for people with serious, debilitating mental illness. There is a huge need for managed crisis care and graduated return to appropriate living situations, where possible with family. There is also a need for more drug and alcohol rehabilitation services.

Governments and agencies should establish a 'triage' set of pathways for providing appropriate care and eventual return to family and/or the community for people with a severe mental illness.

There is a quite separate need for emergency shelter and accommodation for people who have become homeless through factors such as domestic violence, erosion of affordable housing and unemployment and who should not be deemed mentally ill or have their lot cast in with those who are. Provision of such shelter would be a preventative measure. While social issues might for some lead to mental illness, timely intervention to put the person in a safe and secure environment will go a long way to preventing the downward spiral of subsequent severe distress and eventual mental illness. The trendy 'tiny house' movement and the homeless 'backpack swags' risk becoming ghetto targets and having more seriously mentally-ill among them could guarantee them remaining undesirable places.

Government and agencies should establish a set of pathways with the aim of putting the person in a position which minimises their loss of social status as a preventive measure.

Here's what will not work:

- Changing legislation to force private landlords and the community generally to accept people with a mental illness, particularly those with potential violent tendencies. People will be careful about what they say but still discriminate;
- Social engineering campaigns aimed at attitude change and normalising mental illness. These benefit everyone except those most in need of care and services;
- Throwing money at the problem without clearly defining who is the beneficiary of that money. There will be a flood of applications/claims from people who are functioning well enough to make such a claim while the real issue is ignored.
- Creating ghettos by mixing people with severe mental illnesses in with those with the less severe forms or no actual mental illness but unfortunate circumstances

Recommendations:

1. Provide emergency crisis care and shelter for people with a mental illness, including in rural areas.
2. Provide separate emergency shelter and services for the non-mentally-ill homeless as a preventative measure, including in rural and regional areas.

#### *QUESTIONS ON SOCIAL SERVICES*

*How could non-clinical mental health support services be better coordinated with clinical mental health services? Are there significant service gaps for people with psychosocial disability who do not qualify for the NDIS? If so, what are they? What continuity of support are State and Territory Governments providing (or plan to provide) for people with a psychosocial disability who are ineligible for the NDIS? Are the disability support pension, carer payment and carer allowance providing income support to those people with a mental illness, and their carers, who most need support? If not, what changes are needed? Is there evidence that mental illness-related income support payments reduce the propensity of some recipients to seek employment? How could mental illness-related income support payments better meet the needs of people whose capacity to work fluctuates over time?*

The NDIS has pretty much locked out psychologists. No funding is available for the assessment phases that determine NDIS eligibility. Assessment was one of the traditional functions of psychology. Nor is there any provision in NDIS for psychologists to host any sort of individual or group sessions. So NDIS is largely irrelevant to psychologists.

MCA has no information on the other practitioner groups affected by the funding.

Capacity to work as a measure makes the grand assumption that there is work available if their capacity improved. Many places have high unemployment rates even for well-qualified persons with no mental illness. Even volunteer work is now competitive, requiring ability to lift. Age discrimination keeps many people ineligible for work whatever their capacity. Some casual work does not cover the cost of going to the workplace. This becomes a national issue when housing prices make it unaffordable to live near enough to get to the workplace. These are society problems not likely to be changed by improved mental health.

#### *QUESTIONS ON SOCIAL PARTICIPATION AND INCLUSION*

*In what ways are governments (at any level) seeking to improve mental health by encouraging social participation and inclusion? What evidence is there that public investments in social participation and inclusion are delivering benefits that outweigh the costs? What role do non-government organisations play in supporting mental health through social inclusion and participation, and what more should they do? Are there particular population sub-groups that are more at risk of mental ill-health due to inadequate social participation and inclusion? What, if anything, should be done to specifically target those groups? What indicators are most useful to monitor progress in improving mental health outcomes through improved social participation and inclusion?*

These concerns conflate those with serious mental illnesses and others assigned that label. Some persons with serious mental illness are highly disruptive. Even if they are not physically violent a single individual can disrupt an otherwise cohesive social group. Even a quiet depressed person can lower the tone for a group. The proliferation of MeetUp groups online and dating services attests to the difficulties of people who don't have the extra burden of mental-illness finding companionship.

Discrimination provisions can sometimes give the more vocal and dangerous formerly asylum-level mentally ill persons a 'green light' to be disruptive and abusive, playing the 'mental illness card' if anyone challenges them. We see codes of conduct that prevent discrimination against people with "infectious diseases" being taken as a license to cough and sneeze over others in public places.

#### *QUESTIONS ON JUSTICE*

*What mental health supports earlier in life are most effective in reducing contact with the justice system? To what extent does inadequate identification of mental health and individual needs in different parts of the justice system increase the likelihood, and extent, of peoples' future interactions with that system? Where are the gaps in mental health services for people in the justice system including while incarcerated? What interventions in the justice system most effectively reduce the likelihood of re-offending, improve mental health and increase prospects for re-establishing contributing lives? What evidence is there about the long-term benefits and costs of these interventions? What are the main barriers to lowering the over-representation of people living with a mental illness in the justice system and what strategies would best overcome them? To what extent do inconsistent approaches across states and territories lead to inefficient, ineffective or inequitable outcomes for offenders and their families?*

This is a wide area to cover, so we restrict our comments to the criminal justice system and suggest the following: It seems illogical to expect there to be other than an "over-representation of people living with a mental illness in the

*justice system*". By definition the justice system deals with abnormal and/or anti-social behaviour. It covers treatment of alleged offenders by police, the courts and the prison system from entry to incarceration, to release and prevention of recidivism. The problems arise with conflating all mental illnesses together and labelling common human propensities to violence or dishonesty as aberrations, hence 'illness'.

Ever since justice systems took account of motives there has been trouble reconciling this with the unfathomable motives of the seriously psychotic. The current standards descend from the 1843 M' Naghten defence of a murder on the grounds of insanity that the party has a mental 'disease', either as a condition or as an episode, cannot know right from wrong and therefore cannot form criminal intent so is not responsible for their crime. Central to our criminal justice system is the concept that to properly stand trial the alleged offender:

- Understands right from wrong
- Feels guilt; and
- Is amenable to rehabilitation and avoidance of recidivism.

The downside is that people might try and game the system such as by feigning psychosis or 'multiple personality' disorder. This has been debated ever since M' Naghten and around the time asylums were closed in the early 60s was well-parodied by the Jets' gang song in 1961 *West Side Story*: " *This boy don't need a judge He needs an analyst's care! It's just his neurosis that oughta be curbed. He's psych-o-logically disturbed*" and the notorious 1979 "Twinkie defence" that related a murder to depression and change of diet to sugary Twinkie cakes.

It should be noted that anecdotal evidence from people suffering from serious mental illness, who experience episodic lapses or relapses feel extreme guilt and shame for their actions once the 'episode' is over. There is no evidence that people with less serious mental illnesses do not have also experience such heightened shame and guilt following incidents. The only exception might be some personality disorders where inability to empathise is part of the disorder. Corrective Services have for some time run rehabilitative programmes for those convicted of domestic abuse. These might be appropriate for non-psychopathic persons who had developed sub-culturally-condoned violence -ie- a belief that this was required of them as proof of masculinity. They might learn alternative beliefs.

Under the law, there is a low thresh-hold to establish intent or responsibility. This is further complicated by the fact that a person who is affected by alcohol or drugs does not avoid responsibility. MCA argues that in the interests of society and the victims of crime, this is appropriate.

One of our members is aware of attempts in NSW to introduce alternative forms of justice to incarceration for non-violent offences. These attempts are partially modelled on International precedents. They include the 'drug court' for drug-related offences, restorative justice measures including regulated and supervised meetings between the victim and offender and Indigenous justice measures where respected elders and other members of the community meet with offenders. These measures were developed and adopted in some other states in advance of NSW but are not available in other jurisdictions.

We support the development and strengthening of these measures across jurisdictions for non-violent crimes. This can be beneficial for the victim who is often left outraged at the inappropriateness of legal sanctions. It can be beneficial for the offender who may for the first time realise that their actions can cause harm. As indicated above, anecdotal evidence is that along with non-psychopathic mental illness comes shame and guilt. Attitudes focussed only on punishment might not result in resolution or change.

Some countries deal with crimes committed by their indigenous populations though alternative forms of justice which take into account the indigenous values and rely on the strong cultural and social ties in the indigenous communities. New Zealand and Canada are examples of two countries which have successfully introduced these measures. In particular these alternative justice practices might provide additional social and psychological support for Indigenous offenders who have a mental illness.

It should be noted that few countries have attempted alternative justice practices, particularly restorative justice, in relation to violent crimes.

#### *QUESTIONS ON CHILD SAFETY*

*What aspects of the child protection programs administered by the Australian, State and Territory Governments are the most effective in improving the mental health of people in contact with the child protection system? What, if any, alternative approaches to child protection would achieve better mental health outcomes*

The NSW Family & Community Services 'mandatory reporting guidelines for children at risk' are vague and should be subjected to ACCC scrutiny. On the one hand FACS assures practitioners that they do not have to play an unarmed, uninformed, unauthorized, unprotected unpaid 'detective' role yet on the other hand they say 'you should get more information'. This is scientific and logical nonsense. How would you get more information without probing and asking

for names and addresses? Often all a practitioner might hear is some off-hand remark about some third party. They don't know anything about them, let alone their names or where they live. And probing about them so that bureaucrats can descend on this total stranger's doorstep to inquire about paedophilia would seem to put a practitioner at risk if they knew who 'dobbed them in'. Even innocent parties would be upset.

The patients they see in the clinics with serious disorders might have children and seem to pose some risk but that assumes there is some scientific basis for making such judgements. There is no evidence for such powers of prediction.

There might be some cases where a patient actually confesses to performing some child abuse but this might be in a context where this is already known to authorities, who may have been the referring agents in the first place, so it would seem illogical to re-report to them what they already know. Miscreants might be under an illusion that confessions attracted professional privilege as in legal offices and would protect them, but this could be quickly dispelled.

These sorts of concerns blow out the costs and hamper psychological practices. Elaborate consent forms are devised that outline patients' rights, privacy, confidentiality, and even possible side-effect of psychotherapy – as if we were talking about a dental root canal or surgery and knew such answers. All this may keep lawyers happy and may even provide a bit of placebo effect by making it all seem 'potent' but it is a cumbersome way to start a first session.

This sort of legislation keeps politicians happy but leaves practitioners on edge with conflicting guidelines and fear of being struck off over 'failing to act' on some third-hand gossip. The Royal Commission into Institutional Responses to Child Sexual Abuse investigated residential institutions, out-of-home care, schools, sport, recreation, arts, culture, community and hobby groups, detention environments and religious institutions. Mental-health workers should not be assumed to have any greater predictive powers than the public. All citizens have a duty to report crime but not to act as unprotected detectives.

#### *QUESTIONS ON EDUCATION AND TRAINING*

*What are the key barriers to children and young people with mental ill-health participating and engaging in education and training, and achieving good education outcomes? Is there adequate support available for children and young people with mental ill-health to re-engage with education and training? Do students in all levels of education and training have access to adequate mental health-related support and education? If not, what are the gaps? How effective are mental health-related supports and programs in Australian education and training settings in providing support to students? How effective are programs in educating staff, students and families, on mental health and wellbeing? What interventions are most effective? What evidence exists to support your assessment? Do teachers and other staff in schools and education facilities receive sufficient training on student mental health? Do they receive sufficient support and advice, including on the quality and suitability of different approaches, to adequately support students with mental ill-health? What overseas practices for supporting mental health in education and training should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?*

Much focus on 'education and training' is premised on the notion that they will subsequently get jobs on the basis of the education and training. Employment is a problem for society as a whole, rather than being specific to mental illness.

There is a danger in coopting school teachers into identifying supposed mental-health problems in the schools. The notorious 'bounty-hunting' practices were a cautionary tale and there are less overt risks such as launching young people into adulthood with psychiatric labels and drug experience.

One area worthy of action is bullying. But this is nothing new and the Health sector likely has little specific to offer the school education system. Both these sectors and the Police have their own high levels of reported bullying by colleagues and stress-leave claims. Anti-bullying campaigns are society-level and require cultural change to get rid of dangerous tradie 'hazing' rituals, dobber-shaming and the like.

#### *QUESTIONS ON GOVERNMENT-FUNDED EMPLOYMENT SUPPORT*

*How cost effective have the Australian Government's Disability Employment Service (DES) and Personal Helpers and Mentors service (PHaMs) been in enabling people with a mental illness to find and keep a job? Have the DES and PHaMs been targeted at the right populations? What alternative approaches would better support people with a mental illness (whether episodic or not) to find and keep a job? To what extent has the workforce participation of carers increased due to the Australian Government's Carers and Work Program? What will the transition to the NDIS mean for those receiving employment support? Which State or Territory Government programs have been found to be most effective in enabling people with a mental illness to find and keep a job? What evidence supports this? How could employment outcomes for people experiencing mental ill-health be further improved?*

Unemployment is a society-level issue. If qualified non-ill able-bodied people are not able to find work in a given

region why would one expect someone with an extra burden such as a mental illness to 'find and keep a job'? Losing a job is depressing. A psychotic or thought-disturbed person gaining more insight might merely see their bleak unemployment prospects more clearly.

#### *QUESTIONS ON MENTALLY HEALTHY WORKPLACES*

*What types of workplace interventions do you recommend this inquiry explore as options to facilitate more mentally healthy workplaces? What are some of the advantages and disadvantages of the interventions; how would these be distributed between employers, workers and the wider community; and what evidence exists to support your views? Are employers pursuing the potential gains from increased investment in workplace mental health which have been identified in past studies? If so, which employers are doing this and how? If not, why are the potential gains not being pursued by employers? What are some practical ways that workplaces could be more flexible for carers of people with a mental illness? What examples are there of best practice and innovation by employers? How can workplace interventions be adapted to increase their likelihood of having a net benefit for small businesses? What role do industry associations, professional groups, governments and other parties currently play in supporting small businesses and other employers to make their workplaces mentally healthy? What more should they do? What differences between sectors or industries should the Commission take account of in considering the scope for employers to make their workplaces more mentally healthy? Are existing workers' compensation schemes adequate to deal with mental health problems in the workplace? How could workers' compensation arrangements, including insurance premiums, be made more reflective of the mental-health risk profile of workplaces? What overseas practices for supporting mental health in workplaces should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?*

Anti-bullying campaigns are a society-level issue requiring cultural change. Health, Police and Education sector employees are no better at solutions than anyone else. Indeed, teachers have a high incidence of OH&S stress claims from bullying by colleagues and parents, let alone students.

#### *QUESTIONS ON REGULATION OF WORKPLACE HEALTH AND SAFETY*

*What, if any, changes do you recommend to workplace health and safety laws and regulations to improve mental health in workplaces? What evidence is there that the benefits would outweigh the costs? What workplace characteristics increase the risk of mental ill-health among employees, and how should these risks be addressed by regulators and/or employers?*

Again, anti-bullying campaigns are a society-level issue requiring cultural change.

#### *QUESTIONS ON COORDINATION AND INTEGRATION*

*How effective are the governance and institutional arrangements for mental health in Australia in achieving the objectives agreed by COAG Health Council in the Fifth Plan? How can they be improved? To what extent do current governance and institutional arrangements promote coordination and integration of mental health services and supports across health and non-health sectors and different levels of government? What are the barriers to achieving closer coordination of health, mental health and non-health services and how might these be overcome? Is the suite of documents that comprises the National Mental Health Strategy effectively guiding mental health reform? Does it provide government and non-government stakeholders with clear and coherent policy direction? If not, what changes could be made? Are there aspects of mental health governance where roles and responsibilities are unclear or absent? Are the mechanisms for holding government decision-makers accountable for system performance sufficiently well-defined?*

With such a high proportion of practitioners already left out of the funding and constantly battling against proposals to push them further out of work it is no surprise that things are uncoordinated. MCA members have attended meetings where 'consumer focus' and 'service' are bandied around with no notice whatsoever that the health care providers in the audience might themselves be nearly in tears, ready to resign as they are well below the poverty line year after year in a vain chase for their provisional registration, barely able to afford petrol to drive between their next volunteer gigs. A clean-up of the AHPRA registration process through an ACCC inquiry, as required by law, might at least bring these practitioners back to the table.

*QUESTIONS ON FUNDING ARRANGEMENTS* *What have been the drivers of the growth in mental health expenditure in Australia? Are these same forces likely to continue driving expenditure growth in the future? What new drivers are likely to emerge in the future? Can you provide specific examples of sub-optimal policy outcomes that result from any problems with existing funding arrangements? How could funding arrangements be reformed to better incentivise service providers to deliver good outcomes, and facilitate coordination between government agencies and across tiers of government? Are the current arrangements for commissioning and funding mental health services — such as through government departments, PHNs or non-government bodies — delivering the best outcomes for consumers? If not, how can they be improved? How does the way the Medicare Benefits Scheme operate impact on the delivery of*

*mental health services What changes might deliver improved mental health outcomes What government services and payments beyond those directly targeted at mental health should this inquiry seek to quantify, and how should this be done?*

Current funding for bulk-billed services is working only marginally. Few if any can sustain a practice without a gap fee. It all hangs on referrals from GP's and their preferences. The distortions in the market would be made far worse if the multi-tiered proposals are taken up. Practices will close. Australia will end up funding a small over-paid unaccountable elite collecting tax dollars sitting in front of telehealth screens while their former colleagues queue at Centrelink. That is no exaggeration as it is already happening.

#### ***QUESTIONS ON MONITORING AND REPORTING OUTCOMES***

*Are decision-making forums for mental health receiving high quality and timely information on which to base strategic decisions Does Australia have adequate monitoring and reporting processes to assure compliance with national standards and international obligations Is there sufficient independence given to monitoring, reporting and analysing the performance of mental health services Which agency or agencies are best placed to administer measurement and reporting of outcomes? What does improved participation, productivity and economic growth mean for consumers and carers? What outcomes should be measured and reported on What approaches to monitoring and reporting are implemented internationally What can Australia learn from developments in other countries To what extent is currently collected information used to improve service efficiency and effectiveness?*

The focus on 'outcomes' has been an appealing catch-cry for psychiatrists promoting the multi-tiered system. They claim they have the 'outcome data' that justifies more money spent on their psychiatric teams and 'highly-skilled' clinicians instead of general psychologists and other allied health providers. This is a flawed argument. Psychiatric facilities treating the sort of people who used to be asylum in-patients might well show better outcomes. But that is a tribute to the resources and custodial facilities, not necessarily the skills of the staff.

Asking suburban allied health professionals and GP's to report outcomes is a pipe dream. An outcome might only be known if the patient returns and fills in some questionnaire. Who do they propose will invade privacy to ring this former patient, ask them to come in to the clinic, hand out and collect the questionnaire? The receptionist? The GP? The psychologist? And who will pay for all this? Will MBS create a funding item for receptionists or follow-ups? Will the Privacy Act exempt them if someone objects to the home privacy intrusion -ie- 'this is the mental health clinic calling – is so&so home'? Independently-funded monitors might do this but to expect urban practices to do it only imposes yet another unrealistic unscientific burden and highlights the greater resources available to teaching-hospital programmes that make such data collection a requirement for more desperate patients to participate in their drug trials. An ACCC investigation might force burden of proof as to whether these drug trials actually produce any medicines that do more good than harm.

Suicide rates are constantly peddled as global outcome indicators. They are too unpredictable to be reliable indicators of the overall mental health of the community. World-wide suicide rates reflect trends like employment and availability of