



**Private Mental Health Consumer
Carer Network (Australia) Limited**

engage, empower, enable choice in private mental health

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Submission

To the

Productivity Commission Inquiry into Mental Health

Dated 27 March 2019

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Executive Summary

We thank Productivity Commission for the opportunity to provide input into the Inquiry into Mental Health.

The *Private Mental Health Consumer Carer Network (Australia)* (hereafter Network) represents Australians who have private health insurance or who receive their treatment and care from private or office based settings for their mental illnesses or disorders and also represent their carers. As our title implies, the Network is the representative voice for consumers and carers in private mental health settings. We are highly informed about consumer and carer concerns and the operations of private providers.

The main topics we wish to cover in this Submission relate to the issues for people with a lived experience of mental illness when using mental health services and supports together with issues relating to carers, family and friends.

We have covered the following in particular:

- 1 Capacity building
- 2 Rural and Remote
- 3 Emergency Departments
- 4 Structural weaknesses identified in past reviews
- 5 Suicide
- 6 Borderline Personality Disorder
- 7 Comorbidities
- 8 Housing and Homelessness
- 9 Employment
- 10 Disability Support
- 11 Justice system
- 12 Expansion of the Peer Workforce
- 13 National Mental Health Strategy – private mental health sector
- 14 Health Insurance Reform

We have also included a number of recommendations which we would be grateful if the Productivity Commission would consider.

The private mental health sector is a very significant player in the mental health space. We refer you to a brief overview of the data relating to this sector in Section 13. Health insurance premiums are increasing at a rapid rate, and the Network is concerned that the value for psychiatry cover seems to be decreasing. Restrictions, conditions etc will continue to affect the value of health insurance for psychiatry even with the introduction of the categorisation of products into Gold, Silver, Bronze and Basic on 1 April 2019.

The Network has made many Submissions in the past. We are in the unique position of being able to advise from our direct lived experience of either consumers or carers about what works and what doesn't. If we are to look at true patient centre care, then we need to consider a whole new way of doing business. What is required is to listen to the experiences of consumers and carers and look to build a mental health system that meets their needs, rather than building a system and expecting them to fit it.

We are hopeful that this Inquiry of the Productivity Commission will do exactly that. Listen to, engage with and move forward with us. There is much to be gained including better targeting funding, resources and workforce.

We would welcome the opportunity to discuss any of the issues and recommendations raised within this Submission.



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Recommendations

We have made a number of Recommendations which we would be grateful if the Productivity Commission would consider. These are:

Capacity Building

➤ Recommendation 1:

Young people:

- i. Introduce the Be You program into all schools across Australia.

Carers:

- ii. Address barriers to health insurers paying benefits for carer psychoeducational and support groups provided within private psychiatric hospitals.

Rural and Remote

➤ Recommendation 2:

Workforce:

- i. Introduce an incentive payment to the mental health workforce similar to that which applies to teachers with an upfront payment to relocate, followed by an additional payment once employment has reached 18 months and a final payment once the term of employment has reached 36 months.
- ii. Provide greater peer support for overseas trained psychiatrists and other clinicians and greater education about the Australian mental health system provided by the relevant state or territory Government.

Enhanced MBS Item No:

- iii. Expand the current availability of telehealth to children and young people via new MBS item number/s.

➤ Recommendation 3:

Introduce a heightened media awareness campaign targeting the local geographic area of government, non-government, resources and support group availability.

Part of that campaign would be to tackle stigma with a focus on employing people with a mental illness.

➤ Recommendation 4:

Where local CALD and/or Refugee communities are significant in number, that policy be developed to ensure the design and provision of mental health services meet their cultural and language needs.

Emergency Departments (EDs)

➤ Recommendation 5:

- i. Establish short stay units in all Emergency Departments and offer access to a psychologist of up to five sessions to people presenting to EDs with mental health issues.
- ii. Establish the 'Safe Haven model' model in all jurisdictions, staffed by peer workers.

Suicide and suicide prevention

➤ Recommendation 6:

- i. Introduce targeted prevention strategies for men.
- ii. Introduce targeted prevention strategies for the rural and remote areas.
- iii. Fund the training and education of country staff including ambulance, police and administrative staff of suicide awareness.
- iv. Implement reporting protocols of deaths within 28 days of discharge from a mental health facility be linked to coronial reporting requirements.
- v. Implement the reporting of any death within 28 days from consultation with a health professional for a mental health issue, be linked to coronial reporting requirements.
- vi. Introduce suicide prevention training be provided to health and community workers who provide services to individuals with a mental illness.
- vii. Implement the mandatory introduction and routine use in public and private mental health sectors of a clinician rated, validated suicide risk assessment tool at admission and discharge from inpatient settings and 3 monthly review in community settings.
- viii. Introduce and routine use of a clinician rated, validated suicide risk assessment tool for all people in contact with community mental health support organisations.
- ix. Provide community-based assertive outreach to people who have attempted suicide.
- x. Provide community-based supports for families and or significant others affected by suicide or suicide attempt.
- xi. Fund a range of targeted community mental health supports to reduce the risk of subsequent suicide following discharge from hospital or other care. Follow up should occur through multiple channels (in person, by phone), and should not be dependent on the nature of any other service the person is receiving or has received, or how that service is funded (Commonwealth or State).

High Risk Groups: Borderline Personality Disorder

➤ Recommendation 7.

- i. Implement Recommendation 25, of the Senate Community Affairs, Toward recovery: mental health services in Australia.
- ii. Increase the number of consultations under the Better Access initiative for people with BPD to the same as eating disorders, i.e. 40 per year.

Comorbidities – mental illness and physical

➤ Recommendation 8.

- i. Create a simple mechanism by which people with GI disease are able to access MBS funding for Psychological care for four sessions when referred directly by their Specialist Gastroenterologist or Physician.
- ii. Provide community based collaborative care to people with co-morbid physical and mental illnesses.
- iii. Provide a similar program by raising a new MBS item number offering yearly health check to people with mental and chronic physical illnesses such as that currently provided for indigenous people 45+ under MBS item number 715.

Housing and homelessness

➤ Recommendation 9.

- i. Expand the mental health and homelessness services across all jurisdictions.
- ii. Establish more community residential facilities which offer 'step up, step down' support
- iii. Adopt a Housing First for 15 – 24-year olds with mental illness at risk of homelessness.
- iv. Introduce this model more broadly for people with mental illness experiencing homelessness.

Employment

➤ Recommendation 10:

- i. Encourage supported employment for people with severe mental illness by targeting employers.
- ii. Provide support to people with a severe mental illness to gain and maintain employment.

➤ Recommendation 11.

- i. Support the roll out of the Individual Placement and Support Program across all headspace sites in Australia.
- ii. Establish the VETE services within all jurisdictions.

Social Services:

➤ Recommendation: 12.

Add an additional question about a consumer's 'insight' or 'judgement' to the Medical/Assessment form for application for Carer Payment and Carer Allowance

Greater engagement with families

➤ Recommendation 13.

Introduce training to staff in how to better engage with carers and families by the implementation of: The Practical Guide for Working with Carers of People with a Mental Illness.

Expansion of the Peer Workforce

➤ Recommendation 14.

- i. Increase the number of peer workers across Australia.
- ii. Establish and expand the range of services provided and led by peer workers

National Mental Health Strategy

➤ Recommendation: 15.

Include representation of the private sector should be undertaken at beginning of any initiative relating to the National Mental Health Strategy and any plans beyond the current Fifth National Mental Health and Suicide Prevention Plan including membership of any writing group.

Health Insurance Reform

➤ **Recommendation 16:**

- i. All health insurers and private hospitals provide a transparent process which allows consumers to compare mental health treatment options at the point of admission to inpatient or day programs
- ii. All health insurers and private hospitals provide written advice on what conditions, restrictions or requirements they have in place under the HPPAs which will allow consumers, families and treating psychiatrists information upon which to make an informed decision about their treatment.

1 Capacity building

Children

There are a number of areas that the Productivity Commission has raised. The Network would like to comment on building the capacity of the Australian population to stay well and mentally healthy.

We believe this starts with school aged children and those whose parents have mental illness. A number of initiatives have been introduced in this area and the Network strongly supports these. Of note is our interest in the Be You schools initiative and how young children who show early signs of heightened sensitivity or other issues can be assisted in building their capacity to deal with themselves and the world around them. We heard recently from a presentation by Beyond Blue that as many six school aged children each year take their lives by suicide. This is the worst statistic the Network has heard. *Please see our commentary in the Suicide Section below Page 11.*

Informal Carers

Carers also require supports to undertake their role and services are required to build their capacity to do so. There are significant issues in relation to their lost or reduced employment and hence cause strain on finances, their own mental and physical wellbeing, housing, and other issues.

Mind Australia commissioned the University of Queensland to undertake research in the carer area and in March 2017 released the Report: *The economic value of informal mental health caring in Australia: summary report*. Some of the Key findings were that there are an estimated 240,000 Australians care for an adult with mental illness. In June 2015, there were an estimated 2.8 million informal carers in Australia, of whom 240,000, or 8.6%, were mental health carers meeting our definition. This group comprised 54,000 primary carers and 186,000 other mental health carers. It would cost \$13.2 billion to replace informal mental health care with formal support services.

Carer respite and carer psychoeducational and support groups in private hospitals

The Network also notes that the funding previously allocated to carer respite has been diverted into the NDIS.

We are also aware that health insurers do not pay benefits for carer psychoeducational and support groups or services provided within private psychiatric hospitals.

➤ Recommendation 1:

Young people:

- i. Introduce the Be You program into all schools across Australia.**

Carers:

- ii. Address barriers to health insurers paying benefits for carer psychoeducational and support groups provided within private psychiatric hospitals.**

2 Rural and Remote

There are still a number of problems or barriers to accessing mental health services, and current gaps in service delivery despite a number of Inquiries.

There is a very limited number of Australian psychiatrists who practice outside metropolitan cities. Throughout country Australia, mental health delivery by psychiatrists is via a limited number of Consultant Psychiatrists flying in/flying out for a limited period of usually one day. This does not allow for timely follow up in crisis situations, close monitoring, or long-term psychological therapies. Whilst psychologists are more accessible in regional areas, a similar situation applies regarding rural and especially remote locations. The Federal Government incentive for Psychiatrist Office based IT or web teleconferencing goes some way to address these needs, however there is evidence that the uptake has been slow.

The mental health needs of people in rural/remote areas are currently catered for by small community mental health teams. These clinicians provide much needed mental health care though in a limited capacity and can consist of one clinician working in isolation, or two or more working as a team. The more remote the location, the smaller number of clinicians. Whilst the workforce consists of mental health nurses, sometimes Occupational Therapists, sometimes psychologists and/or Social Workers, the ability to administer and monitor psychotropic medications, to provide crisis interventions, long term therapy etc is limited.

Psychiatrists have the opportunity to provide telehealth through the MBS¹² currently but more needs to be done to extend and retain these items. Furthermore, it is essential for children and young people in rural areas by using the same technology available to adults that they have access to a child and adolescent specialist or other appropriate clinician.

➤ **Recommendation 2:**

Workforce:

- i. **Introduce an incentive payment to the mental health workforce similar to that which applies to teachers with an upfront payment to relocate, followed by an additional payment once employment has reached 18 months and a final payment once the term of employment has reached 36 months.**
- ii. **Provide greater peer support for overseas trained psychiatrists and other clinicians and greater education about the Australian mental health system provided by the relevant state or territory Government.**

Enhanced MBS Item No:

- iii. **Expand the current availability of telehealth to children and young people via new MBS item number/s.**

Stigma also plays a huge part in impeding mental illness identification and treatment. Both men and women in small communities often seek assistance from health professionals outside of their local community, especially for mental health issues, for fear of the reaction of others within their small social environ. This heightened stigma in rural and remote communities remains an obstacle to the utilisation of mental health services partly due to the size of the communities and the close association people have with each other in social, community and employment situations.

➤ **Recommendation 3:**

¹ MBS Item Number 288 - Professional attendance on a patient by a consultant physician practising in his or her specialty of psychiatry

² MBS Item Number 353 - A telepsychiatry consultation by a consultant physician in the practice of his or her specialty of Psychiatry

Introduce a heightened media awareness campaign targeting the local geographic area of government, non-government, resources and support group availability.

Part of that campaign would be to tackle stigma with a focus on employing people with a mental illness.

Increasingly, significant numbers of Culturally and Linguistically Diverse (CALD) and refugee groups are being re-located in regional and rural areas and a very recent government announcement refers to this. Specific refugee populations are now being relocated to specific areas i.e. Afghan refugees to Rockhampton for employment within the local abattoir. These geographic areas need to have mental health services which are user friendly and appropriate to address specific cultural and language needs. The question arises, are services being delivered and designed to attract local CALD or refugee communities, if not, then we would recommend that they are. The Network believes that policy should be developed around ensuring that mental health services cater to their respective local geographic CALD and/or refugee communities.

➤ **Recommendation 4:**

Where local CALD and/or Refugee communities are significant in number, that policy be developed to ensure the design and provision of mental health services meet their cultural and language needs.

In terms of recruitment of psychiatrists and other mental health professionals to fill the needs of mental health consumers in rural and remote areas the following are currently in place.

Overseas Trained Psychiatrists are required to undertake additional education. The Specialist Pathway of the RANZCP is a pathway to College Fellowship and only suitable for Overseas Trained *Specialists* (OTS) with a recognised Specialist Qualification who wish to remain and work in Australia permanently. Given that mental health is largely about ‘talking therapy’ language and strong accents by OTS can be an issue for consumers.

The other pathway to RANZCP College Fellowship is to recruit to an Area of Need. Areas of Need are declared by the States and Territories for rural and remote areas when the jurisdictional governments offer employment. The Overseas Trained psychiatrists in these positions are often unsupported by the Governments where they are required to practice often in isolation within a mental health system which is complex and foreign. This can act as a deterrent in recruitment and retention.

3 Emergency Departments

We are seeing a number of initiatives previously funded by the Australian Government stop once the funding has ceased. The Network strongly supports short stay units as an alternative to Emergency Department (ED) presentations, and the brief intervention services of some ED which provide up to five sessions with a psychologist for people with mental health issues who present to the ED.

Beyond Blue has recently supported the establishment of the first ‘Safe Haven Café’³ concept at St Vincent’s Hospital campus⁴ in Victoria. This is an alternative for people with mental illness to be supported by peer workers rather than presenting to EDs. It is based upon the successful model in the UK and provides a safe alternative for adults over 18 years experiencing loneliness, personal difficulties, or needed social connection. It is open usually during non-clinical contact hours offering

³ Safe Haven Café, Developed in the UK

⁴ St Vincent’s campus at Fitzroy in partnership with Better Care Victoria

support to people with mental illness or experiencing homelessness. Please also see the section on homelessness later in this Submission.

In 2016-17, 276,954 people presented at overstretched public hospital emergency departments seeking care for mental health related conditions. Only 38 per cent of those people were admitted to hospital or referred to another hospital for admission⁵, indicating the needs of around 62 per cent (166,172) of people presenting to public hospital emergency departments were not met.

➤ **Recommendation 5:**

- i. **Establish short stay units in all Emergency Departments and offer access to a psychologist of up to five sessions to people presenting to Eds with mental health issues.**
- ii. **Establish the 'Safe Haven model' model in all jurisdictions, staffed by peer workers.**

4 Past reviews

The Network has had representation on the Improved Models of Care Working Group (IMCWG) and the IMCWG Mental Health Sub Group. A number of issues have concerned us in relation to mental health reform of the private health insurance industry.

We welcome the Minister for Health, Hon Greg Hunt MP, announcement of the immediate upgrade for people requiring admission to a private psychiatric hospital and whose health insurance product does not full cover costs. We also welcome Minister Hunt's announcement that all health insurance products will be categories into Gold, Silver, Bronze and Basic with all but gold having a basis default benefit which is approximately one half of the total costs with the gap being paid by the consumer.

Furthermore, we are advised that even those on the Gold category could have current or new restrictions placed on their policy by way of the Hospital Purchaser Provider Agreements (contracts) between health insurers and hospitals. The most common are 28-day readmission at a lower benefit payable, those attending day programs and requiring re-admission to inpatients, again at a lower benefit payable. We believe that if Australia is to continue to have a viable private health insurance system and for people to attend private psychiatric hospitals, then these restrictions must be removed.

People are finding it difficult to afford increasing health insurance product premiums and struggle to meet these costs questioning the value of health insurance. The public mental health system will not be able to cope with the increased influx of people who are or will drop out of health insurance.

PRODUCTIVITY COMMISSION: ISSUES PAPER

QUESTIONS ON SPECIFIC HEALTH CONCERNS

5 Suicide and suicide prevention

The Network recognises the enormous costs of suicide in Australia. The personal, social and emotional costs left after the suicide of someone close are immeasurable. In addition to grief, emotions of guilt, blame, anger and frustration are all felt by families, friends and work colleagues. People find it hard to fathom why someone chooses to take their own life. Both grief and guilt are

⁵ Australian Institute of Health and Welfare. Table ED.10: Mental health-related emergency department presentations in public hospitals, by episode end status, states and territories, 2016-17

often heightened for those left after a suicide because of their belief that the death could have been avoided and that in some way some responsibility rested with them and their inaction.

Suicide is a topic the Australian community does not openly discuss as a general rule, and the community seems more comfortable in avoiding the matter. Families will report that following death by suicide of a family member, people i.e. friends, neighbours etc tend to react in a negative manner toward them, often avoiding them or avoiding talking about the death (or life) of their loved one. Many of us exposed to the mental health area know people who have chosen this path as a solution to their suffering or know their families. Suicide within mental health is a reality - with some people living with suicidal thoughts on a daily basis.

In 2017, 3,128 lives were lost to suicide.⁶ The biggest risk factor for suicide is a prior suicide attempt. Assertive outreach approaches to integrated suicide prevention can prevent 21 per cent of suicide deaths and 30 per cent of suicide attempts⁷. Every individual who has attempted suicide and sought hospital treatment for a related injury should be followed up.

All governments have made the following commitment to Australians: "Services will actively follow up with you if you are at a higher risk of suicide, including after a suicide attempt."⁸

Despite the large amount of funding over several years, the suicide rate has increased. The Network provided the following Recommendations to the Senate Community Affairs Committee, Inquiry into Suicide in Australia⁹. We still believe these are relevant for the Productivity Inquiry.

There are insufficient services to support families, carers or significant others when a person has attempted suicide or has died by suicide. This is a vulnerable time and people require the necessary mental health supports at this time. We know that it is not uncommon for a sibling, or child of someone who suicides, to also die via suicide. This is a known time of vulnerability and mental health services must be established to cater for this group.

In terms of suicide prevention within mental health, the Network draws the Commission to our recommendations below together with Recommendation 8 (People at high risk, Borderline Personality Disorder) within the mental health sector. We believe such practical measures will go a great way in identifying and reducing suicide to these vulnerable individuals.

➤ **Recommendation 6:**

- i. Introduce targeted prevention strategies for men.**
- ii. Introduce targeted prevention strategies for the rural and remote areas.**
- iii. Fund the training and education to country staff including ambulance, police and administrative staff of suicide awareness.**

Suicide whilst an inpatient of a public and private mental health service.

All suicides whilst in the care of inpatient health services are mandatory reporting requirements classified as a sentinel event. These are the subject of coronial inquiries.

⁶ Australian Bureau of Statistics. 3303.0 Causes of Death, Australia 2017. Table 11.1 Intentional self-harm, Number of deaths, 5 year age groups by sex, 2008-2017.

⁷ Black Dog Institute. LifeSpan research. <<https://blackdoginstitute.org.au/research/lifespan>>, accessed 27 September 2018.

⁸ Council of Australian Governments Health Council. The Fifth National Mental Health and Suicide Prevention Plan. August 2017. Page 25

⁹ Submission 10: Private Mental Health Consumer Carer Network (Australia)

Discharge from a mental health service and suicide

It is acknowledged that a number of people suicide within a short period of discharge from a mental health facility. This could be deemed to imply that either discharge has been premature, recognisable risk factors at the time of discharge are not taken seriously or that there is insufficient community referral and support provided following discharge.

We understand that a reliable collection of information of this nature would require linkage of health service data collections with coronial data collection. The Network further understands that it is *not mandatory* for public mental health services to collect this information as part of the national data collection protocol.

Similarly, private mental health services are *not required* to follow up, support or provide services in the community. Any consequential cases of suicide occurring post-discharge can go undetected – or at least, unrecorded. All admissions to private sector mental health facilities are mostly via a private psychiatrist, though in some instances by a GP or other referral and the private psychiatrist, GP or other referrer *discharge the consumer into their own care*. The private hospital is *not required* to initiate any process by which to follow the consumer after discharge. As a result, private mental health facilities are precluded from mandatory reporting of information of this nature.

The Network considers that **the lack of** suicide reporting for mental health services is of major concern. The Network understands that the collection of this kind of follow-up information is hampered by the difficulties imposed by privacy legislation. Whilst a person is in a service's care the service is obliged to collect and report certain information. Once a person is discharged, it becomes very difficult for health service providers including individual practitioners to be aware of this important information.

The Network concludes that efforts must be made to collect, report and review all occasions of death by suicide following discharge from mental health services.

- iv. Implement reporting protocols of deaths within 28 days of discharge from a mental health facility be linked to coronial reporting requirements.**
- v. Implement the reporting of any death within 28 days from consultation with a health professional for a mental health issue, be linked to coronial reporting requirements.**
- vi. Introduce suicide prevention training to health and community workers who provide services to individuals with a mental illness.**
- vii. Implement the mandatory introduction and routine use in public and private mental health sectors of a clinician rated, validated suicide risk assessment tool at admission and discharge from inpatient settings and 3 monthly review in community settings.**
- viii. Introduce and routine use of a clinician rated, validated suicide risk assessment tool for all people in contact with community mental health support organisations.**

Currently, in both public and private mental health settings, part of the routine national data collection requires the completion of a clinician rated outcome measure (HoNOS) and a consumer self-reporting outcome measure (Kessler-10, Basis-32, MHI-38 and in the private sector the MHQ-14) at admission and discharge from inpatient settings, and routinely at 91-day intervals within community settings. The Network considers that, as part of this collection and reporting suite of outcome measures, it would be appropriate to implement a clinician rated and validated suicide risk

assessment measure. The main concern the Network has is the reliable collection of these instruments on a routine basis.

The Network therefore believes that a routinely administered suicide risk assessment measure be introduced as mandatory, for all mental health consumers at admission, discharge from all inpatient settings, and at ninety-one-day reviews of mental health consumers in all community settings.

People most at risk are those who have attempted suicide. Services are urgently needed to recognise and support these people.

- ix. **Provide community-based assertive outreach to people who have attempted suicide.**
- x. **Provide community-based supports for families and or significant others affected by suicide or suicide attempt.**
- xi. **Fund a range of targeted community mental health supports to reduce the risk of subsequent suicide following discharge from hospital or other care. Follow up should occur through multiple channels (in person, by phone), and should not be dependent on the nature of any other service the person is receiving or has received, or how that service is funded (Commonwealth or State).¹⁰**

Return on investments 1.30 for every \$1 invested.

Savings: \$100 million in the short-term savings, \$1.0 billion in long-term savings¹¹

6 high-risk group – Borderline Personality Disorder

Schizophrenia has a suicide rate of around 8-10% of sufferers, and *borderline personality disorder* around the same. It is estimated that up to *one third* of youth suicides have been the result of the existence of borderline personality disorder.

The failure to conduct assessment, analysis and/or research into suicide by and suicide prevention for people with the diagnosis of *borderline personality disorder* - and indeed even any recognition or focus on people with this mental illness - can only be considered a national failure. The suicide rate of people with this diagnosis is estimated to be around 10%. These deaths can be prevented if appropriate and designated services are provided, access and entry to those services are available and people are not further discriminated against.

In an unprecedented move within mental health in Australia, a coalition of the peak consumer and carer national advocacy organisations¹², together with the clinical and key non-government organisations brought this issue to national prominence by lobbying the *Senate Community Affairs Committee – Inquiry into Mental Health*. This resulted in a clear recommendation in the Report tabled in the Australian Senate on 25 September 2008¹³ that a national borderline personality disorder initiative, overseen by a Taskforce is undertaken.

The Recommendation is as follows:

Recommendation 25

The committee recommends that the Australian, state and territory governments, through COAG, jointly fund a nation-wide Borderline Personality Disorder initiative. The committee recommends that the initiative include:

¹⁰ Mental Health Australia 2019 Election Platform

¹¹ KPMG and Mental Health Australia, Investing to Save, Final Report May 2018
https://mhaustralia.org/sites/default/files/docs/investing_to_save_may_2018_-_kpmg_mental_health_australia.pdf

¹² Senate Community Affairs, Toward recovery: mental health services in Australia, Pg 168 9.57 (Submission 53, Private Mental Health Consumer Carer Network (Australia) p.4)

¹³ Senate Community Affairs, Toward recovery: mental health services in Australia

- designated Borderline Personality Disorder outpatient care units in selected trial sites in every jurisdiction, to provide assessment, therapy, teaching, research and clinical supervision;
- awareness raising programs, one to be targeted at adolescents and young adults in conjunction with the program in Recommendation 19 (Chapter 8) aimed at improving recognition of the disorder, and another to be targeted at primary health care and mental health care providers, aimed at changing attitudes and behaviours toward people with Borderline Personality Disorder; and
- a training program for mental health services and community-based organisations in the effective care of people with Borderline Personality Disorder.
- The committee recommends that a taskforce including specialist clinicians, consumers, community organisations, public and private mental health services and government representatives be convened to progress and oversight the initiative.

The Network strongly supports the actioning of these 4 points as they are still unactioned. Additionally, the Network undertook surveys in June 2011 and again in June 2017 around the experiences of consumers and a separate survey for carers. This was an Australian and International first.

Lawn, S., McMahon, J., Zabeen, S. (2017). FOUNDATIONS FOR CHANGE: PART 1 - CONSUMERS: Experiences of CONSUMERS with the Diagnosis of Borderline Personality Disorder (BPD) 2017 Update. Private Mental Health Consumer Carer Network (Australia) Inc: Marden, South Australia, Australia. (60 pages) <http://www.pmhccn.com.au/>

Lawn, S., McMahon, J., Zabeen, S. (2017). FOUNDATIONS FOR CHANGE: PART 2- CARERS: Experiences of CARERS supporting someone with the Diagnosis of Borderline Personality Disorder (BPD) 2017 Update. Private Mental Health Consumer Carer Network (Australia) Inc: Marden, South Australia, Australia. (95 pages) <http://www.pmhccn.com.au/>

McMahon, J., Lawn, S. (2011) Foundations for Change - Experiences of Consumers and Carers Supporting Someone with the Diagnosis of Borderline Personality Disorder (BPD). An Independent Report of the Data from a National Survey Undertaken by the Private Mental Health Consumer and Carer Network, July 2011 ISBN 1 920966 25 0 <http://pmha.com.au/pmhccn/PublicationsResources/Surveys.aspx>

Lawn, S., McMahon, J. (2011) Foundations for Change Part 1- Experiences of Consumers with the Diagnosis of Borderline Personality Disorder (BPD). An Independent Report of the Data from a National Survey Undertaken by the Private Mental Health Consumer and Carer Network, July 2011 ISBN 1 920966 26 9 <http://pmha.com.au/pmhccn/PublicationsResources/Surveys.aspx>

Lawn, S., McMahon, J. (2011) Foundations for Change Part 2- Experiences of Carers Supporting Someone with the Diagnosis of Borderline Personality Disorder (BPD). An Independent Report of the Data from a National Survey Undertaken by the Private Mental Health Consumer and Carer Network, July 2011 ISBN 1 920966 27 7 Peer report

➤ **Recommendation 7.**

- i. **Implement Recommendation 25 of the Senate Community Affairs, Toward recovery: mental health services in Australia.**
- ii. **Increase the number of consultations under the Better Access initiative for people with BPD to the same as eating disorders, i.e. 40 per year.**

7 Comorbidities

The Network is very aware of the existence of other mental illnesses as well as co-existing physical illness. The Network has been working with Professor Jane Andrews, A/Director & Head IBD Service, Dept of Gastroenterology & Hepatology, Royal Adelaide Hospital and Clinical Professor of Medicine - University of Adelaide. Many Gastrointestinal (GI) symptoms are caused, or exacerbated, by mental health issues. As GI symptoms are common, consultations and procedures driven by them generate huge healthcare costs (e.g. colonoscopy, endoscopy, CTs).

There are a lot of research papers currently which clearly show that psychological therapy is highly effective in many GI disorders, but not widely used due to a current barrier wherein Specialist Gastroenterologists cannot directly refer patients. Patients with GI disease currently need to return to their GP for an additional consultation to access MBS funding for Psychology. This creates additional GP MBS costs and means many patients do not receive best practice care.

Together, Professor Andrews and Janne McMahon (Network EO) have made a submission to Minister for Health, Greg Hunt's Office for the following to be strongly considered within the current MBS review.

To create a simple mechanism by which people with GI disease are able to access MBS funding for Psychological care for four sessions when referred directly by their Specialist Gastroenterologist (as is currently allowed by Specialist Paediatricians, GPs and other medical practitioners).

This could be via the use of existing item numbers, with possibilities including:

- Specialist Gastroenterologist providing direct referral to specialist psychologist by adding this function to descriptors of the current MBS item numbers 110, 116, 132, 133
- Inter-relate with MBS item numbers for accessing clinical or specialist psychologists under the Better Access initiative – MBS item numbers 80000 and 80010 - Psychological Therapy Services
- Amending descriptors of these 80000/80010 MBS item numbers to reflect referral by medical practitioner from excluding to including a specialist gastroenterologist or consultant physician

This would:

- Validate to patients the real value of Psychological treatment for these conditions – thus removing a treatment access barrier
- Ensure they are referred to a Psychologist with the appropriate expertise in Brain-Gut issues

Enabling direct referral from specialist Gastroenterologists to Psychologists for MHIs would:

- Save “churn” and costs in healthcare, by reducing repeat consultations, referrals, ED presentations and unwarranted GI investigations, especially colonoscopy (yielding opportunity gains).
- Improve Quality of life and reduce disability/cost for people with GI disease.
- Reduce chronic (more expensive) mental health problems due to delayed recognition and intervention.

➤ **Recommendation 8.**

- i. **Create a simple mechanism by which people with GI disease are able to access MBS funding for Psychological care for four sessions when referred directly by their Specialist Gastroenterologist or Physician.**

- ii. **Provide community based collaborative care to people with co-morbid physical and mental illnesses (see reference below)**
- iii. **Provide a similar program by raising a new MBS item number offering yearly health check to people with mental and chronic physical illnesses such as that currently provided for indigenous people 45+ under MBS item number 715¹⁴**

Savings: \$1.8 billion in savings¹⁵

**PRODUCTIVITY COMMISSION: ISSUES PAPER
QUESTIONS ON HOUSING AND HOMELESSNESS**

8 Housing and homelessness

The Network has great concerns that housing issues and homelessness will increase from 30th June 2019 as we see the current program Partners In Recovery wound back. We believe that those people currently receiving services and who are not accepted onto the NDIS will fall through the cracks. We refer to the Report of Mental Health Australia and KPMG, *Investing to Save*

The Network also recommends a greater uptake of mental health and homelessness service provision across all jurisdictions as well as establishing more community residential facilities which offer ‘step up, step down’ support for a 6 month period for people with significant mental illness who are discharged from acute care or those who are experiencing a deterioration in their mental health who would otherwise require lengthy hospitalisation.

There are some established facilities across jurisdictions which provide these types of support or early intervention as a means of hospital avoidance or reduced length of stay. There are insufficient facilities currently which offer these services.

Recommendation 2.1. We believe that whilst this focusses on young people, we believe this should be broader.

➤ **Recommendation 9.**

- i. **Expand the mental health and homelessness services across all jurisdictions.**
- ii. **Establish more community residential facilities which offer ‘step up, step down’ support**
- iii. **Adopt a Housing First for 15 – 24-year olds with mental illness at risk of homelessness.**
- iv. **Introduce this model more broadly for people with mental illness experiencing homelessness.**

Savings: \$1.6 billion in short term savings, \$4.8 billion in long-term savings¹⁶

¹⁴ Medicare Health Assessment for Aboriginal and Torres Strait Islander people:
http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_ATSI_MBSitem715

¹⁵ KPMG and Mental Health Australia, *Investing to Save*, Final Report May 2018

¹⁶ KPMG and Mental Health Australia, *Investing to Save*, Final Report May 2018

9 Employment

As consumers we know that some form of paid work is the first most important thing for people. It makes people feel included, better about themselves, provides hope, and helps gain self confidence.

We again refer to KPMG and Mental Health Australia's Investing to Save Report: Recommendation 1.4:

- **Recommendation 10:**
- i. **Encourage supported employment for people with severe mental illness by targeting employers.**
 - ii. **Provide support to people with a severe mental illness to gain and maintain employment.**

Savings: \$120 million over two years¹⁷

There are some very effective education and training schemes within some jurisdictions. The Network would like to draw your attention to two which work in very similar ways.

1) Individual Placement and Support – Australian Government Initiative¹⁸

Integrated Employment Initiative – Western Community Mental Health Service, Adelaide

This evidence-based service which commenced in April 2018 aims to improve employment outcomes by co-locating an employment consultant from a local disability employment service with the community mental health teams. The consultant works with consumers from the team by helping them to achieve employment goals, facilitate work related appointments with Centrelink, assist in searching for a job, provide assistance for the interview and manages any emerging issues from the potential employer.

The Network considers this is a wonderful initiative targeting young people.

2) Vocational, Education, Training and Employment (VETE) Program in NSW

We would like to draw the attention of the Commission to the Vocation Education, Training and Employment (VETE) Program in NSW. This is a Program commenced in 2006 to improve employment and education outcomes for NSW mental health consumers which are not restricted to youth as the IPS Program is.

¹⁷ KPMG and Mental Health Australia, Investing to Save, Final Report May 2018

¹⁸ Current Commonwealth Govt commitment to IPS is \$13.6 m for 3 year trial as part of Youth Employment Strategy, 14 Headspace sites across Aust

VETE – EMPLOYMENT & MENTAL HEALTH

The Vocational Education, Training and Employment (VETE) program commenced in 2006 to improve employment and education outcomes for NSW MH consumers.

VETE was embedded within MH services to provide additional clinicians that improve collaboration and partnerships with NGO employment services, enhance MH capacity to support consumer employment goals, implement best-practice models of employment assistance, provide expert assessment and advice to MH clinicians and consumers and aid MH consumers to navigate the state and federal services in place to help them find work. The VETE program is focussed on implementing an evidence-based practice model called Individual Placement and Support (IPS) that has been shown to be world's best practice in helping consumers get jobs.

IPS has seven key principles:

- ▶ Competitive employment is the goal;
- ▶ Job search starts quickly to harness motivation;

- ▶ Program eligibility is based on consumer choice not illness or other factors;
- ▶ Support services are integrated;
- ▶ Support is ongoing and is based on individual need;
- ▶ Consumer preferences are important; and
- ▶ Personalised Benefits counselling is provided.

Recent outcomes from the Hunter New England (HNE) VETE program showed 50.3% of consumers who access VETE IPS achieve their goal of open employment. The HNE program plays an important role in informing the implementation of IPS in NSW along with the assistance of the NSW VETE State coordinator.

VETE programs have gained positive recognition, with two VETE programs awarded NSW Health quality awards (Provision of Mental Health Services) in 2009 and 2010, and a Premier's award for service delivery in 2010.

The VETE program is currently in the process of setting up a further 5 IPS sites across NSW to further assist MH consumers to achieve their goal of getting a job.



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Additionally, we draw the attention of the Commission to Submission 70 on 8th November 2011 to the Standing Committee on Education and Employment on behalf of the VETE Service¹⁹. From that Submission it noted that the service had yielded practical gains for consumers. Of note that between 1 July 2007 and 30 June 2011 by 4 full time equivalent staff of the VETE service:

Outcomes	Number of clients
Employment	246
Education / Training	218
Improved Vocational Skills / Resources	421
Linked with Employment Service Providers	257
Volunteer Work	53
Social Participation	42

Further the Submission notes that over 2,000 mental health consumers were referred during the 4 financial years (2007-2011) The above positive outcomes account for 70% of the 3 1,776 individuals who proceeded with the VETE Service.

The Network believes that if this VETE Service was introduced within all jurisdictions, the uptake of people with mental illness into meaningful employment, education and training, and links with employment service providers will be extremely meaningful.

Some form of training, no matter what that may be, with the hope of engaging in employment is something which makes such a difference to peoples' lives. It can be hospitality (ie working in a café) horticulture (ie working in a plant nursery) furniture repair (ie working for the charities in picking up and repairing furniture for resale). These are the types of training for people with severe psychosocial disability. Education on the other hand, gives people the chance to return to University, TAFE etc with appropriate supports.

➤ Recommendation 11

¹⁹ Northern Sydney & Central Coast Local Health Districts, Mental Health Drug and Alcohol, NSW Ministry of Health authored by Marianna Wong, Vocational Coordinator, Mental Health Drug and Alcohol.

- i. Support the roll out of the Individual Placement and Support Program across all headspace sites in Australia.
- ii. Establish the VETE services within all jurisdictions.

PRODUCTIVITY COMMISSION: ISSUES PAPER

QUESTIONS ON SOCIAL SERVICES

10 Social Services:

Disability Support Pension

The Network strongly believes the retention of the 'safety net' for people on the Disability Support Pension (DSP) must remain. One of the main advantages for people who are in receipt of the DSP is the ability to seek some form of employment with their DSP being suspended for a period of 2 years. This provides them with the confidence, knowing that should their efforts to attain and importantly retain work be unsuccessful because of their disability, there is within the DSP the two year 'safety net' that they can fall back onto. This suspension means that they are not required to go through the application process again with the fear that they may not be accepted again.

Carer Payment and Carer Allowance

The Network has had concerns about the need to better address the needs of mental health carers with amendments required to the assessment process and Medical Report form, assessing people for the carer payment and or carer allowance. We have raised this issue consistently since our Submission to the Senate Select Committee of March 2005.

The Network recognises the indispensable role of carers in the provision of mental health services in Australia and their contribution to the wellbeing of consumers. In the light of their diverse and demanding responsibilities, it is clear that *full-time* carers require a much easier assessment for the person they care for under the current assessment format and the Medical Report Form which does not in our opinion, adequately represent the tasks in their caring role.

In terms of assessment and the form itself, it has a strong focus on physical disability, for example Page 4 has 10 questions, 8 of which relate to physical issues relating to functions of bowels, bladder, toilet use, feeding, transfer from bed to chair etc, mobility, dressing, stairs, and bathing. The one question which could be related to mental illness or psychosocial disability is: grooming relating to personal hygiene which we know affects many people with chronic psychosocial disability

Of concern in relation to the Medical/Assessment Form are:

Section 15 – Cognitive function: These questions make up the abbreviated mental test which again people with psychosocial disability could well find difficulty in responding to. We understand that this is a marker of their ability to function. They may not have any self-awareness of their mental health impairment and may not be able to accurately describe its affects. It does not capture the role that carers frequently undertake around the need to support the person they care for with problem-solving actions which are very hands-on in order to address actions taken by the person they care for as a result of their impaired cognition. Sometimes the need for rectification are very significant and substantial and often occur on a regular basis. This is a part of care provision which is not recognised and section 15 does not account for or reflect this current issue.

This focus and applicability is included in the Disability Support Pension in particular from the *Social Security (Tables for the Assessment of Work-related impairment for Disability Support Pension) Determination 2011* contained on Page 27 – (e) behaviour, planning and decision-making: Example 2:

The Person's judgement, decision-making, planning and organisation functions are severely disturbed.

Question 16 – behaviour: The most relevant questions in relation to mental illness or psychosocial disability are: shows signs of depression, shows signs of memory loss, withdrawal from social contact, display aggression toward self or others, and display inhibited behaviour.

Suicidal ideation: Consideration must also be given to a 6th criterion for people who are experiencing long term suicidal ideation or risks of self-harm. This sees carers being required to ensure the person they are caring for is not left alone at any time as 'they' have raised with the carer their concerns of feeling unsafe all of the time. The carer is unable to leave them to ensure their safety which for many carers, means not being able to go to work.

Highly variable illness: What needs to be reflected in the need to take account of highly variable mental conditions. As chronic illness is the focus of the assessment process and the Medical Report Form, what needs to be understood is that mental illness is not a stable disability in itself.

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

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

➤ **Recommendation: 12.**

Add an additional question about a consumer's 'insight' or 'judgement' to the Medical/Assessment form for application for Carer Payment and Carer Allowance.

PRODUCTIVITY COMMISSION: ISSUES PAPER

QUESTIONS ON JUSTICE

11 Mental Health in the Justice System

Justice, we have noted as 'social' justice rather than the justice system. Social justice is about participation and inclusion which would be addressed by the areas noted above. However, gaols, holding cells, forensic units are full of people with mental illness and very little is done to provide good mental health care. The justice system is one which doesn't get much support in terms of priorities, and the Network believes that it needs to.

We know that people with mental illness, held on a charge event without sentencing find that their DSP ceases. Many require the DSP and rent assistance to enable them to pay rent to keep their accommodation whilst incarcerated within forensic mental health services. Many find that their DSP ceases and they are required to apply for reinstatement upon release. Some find their accommodation also ceases and they are discharged into homelessness.

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?

We wish to highlight to the Commission a study of a consumer's entry into the justice and forensic mental health system. We are happy to further discuss.

Steve has schizophrenia which is complicated by illicit drug and alcohol problems. Steve continues to cease his prescribed medications and becomes psychotic, delusional. He was acting strangely, and his parents called the Triage service. Steve was referred to the local community team where he was deemed to be OK and they told Steve to stop taking drugs and alcohol. Some weeks later Steve was involuntarily admitted by the police to a public inpatient unit. He was unable to be contained and was transferred to a secure unit elsewhere. He was subsequently returned to the original unit, when here was again admitted to the secure unit.

The parents were concerned about him going off his medications yet again after discharge from this episode, as well as what they saw as increasing potential to violence and discussed this with the Consultant Psychiatrist and inpatient and community treatment teams requesting a review, an application for a CTO for injectable antipsychotics and intensive follow up when Steve was to be ultimately discharged into the community. He was then moved to the open ward where he was unable to be contained and again transferred back to the secure unit. After some weeks, Steve was discharged from the secure unit to home with no supports.

He was not put on a depot, and one month later, again went off his medications, this time violently assaulting his mother, causing lasting physical symptoms. He was arrested and placed under 2 guards in a secure unit waiting transfer to the forensic mental health unit. After three months he was again released under bail conditions to the community with a number of requirements in place.

This case sadly shows that the system and the staff let Steve down, as did his own lack of personal responsibility. Steve now has no contact with his mother, his principle carer, and has a pending conviction.

An ability of mental health clinicians to listen to families and carers is crucial.

➤ **Recommendation 13.**

Introduce training to staff in how to better engage with carers and families by the implementation of: The Practical Guide for Working with Carers of People with a Mental Illness.²⁰

²⁰ The Practical Guide for Working with Carers of People with a Mental Illness; <http://pmhccn.com.au/Resources/Practicalguideforworkingwithcarersofpeoplewithamentalillness.aspx> and accompanying resources including: App for use on apple and android phones, iphones, Microsoft Surface Pro, PCs; Carer Resource website <https://workingwithfamiliesandcarers.com.au/> ; online training; <https://helpingminds.org.au/health-professionals/> Carer Nomination Form; <http://pmhccn.com.au/Portals/2/PublicDocuments/training/Carer%20Nomination%20Form.pdf> Information Booklet for Families and other Carers; <http://pmhccn.com.au/Portals/2/PublicDocuments/training/carerinformationbooklet.pdf>

12 Expansion of the Peer Workforce

Peer work is a growing occupational group in the mental health workforce and has been reported to be growing at a faster rate than other disciplines in recent years.²¹ Increasingly, peer workers are being employed within the public mental health system and community managed organisations (CMOs); however, the private sector lags behind in this regard.

Not unexpectedly, however, as a relatively new occupational group, there is still a lack of shared understanding across the mental health sector more broadly of the definitions, values, skills, practices and challenges in peer work. As a relatively new workforce, and with understanding of their role and potential contribution still limited, there is a need to consider how to best support individual workers and to promote the role, including embedding peer workers within mental health services.

While there are currently professional bodies available for other mental health professions and disciplines such as social workers, general practitioners, psychiatrists, nurses, psychologists and occupational therapists, there is no such entity available to promote, provide support, training and advocacy for the mental health peer workforce in Australia.

The essence of peer work is in the unique and personal experiences that individuals bring to the role, specifically the experience of mental illness, treatment, hospitalisation and the recovery journey, or as a family member or carer supporting someone with mental illness.

Peer workers are required to advocate for the consumers and carers they walk alongside, which can lead to further discrimination and harm through re-traumatisation if the staff and management of the organisation they work for do not fully understand the purpose of their role. A peak entity would provide standards and guidelines to be implemented by services and organisations employing peer workers to eliminate further harm, increase understanding of this unique role and maximise the benefits that peer support workers can provide by improving outcomes for consumers and carers.

Emerging evidence indicates peer work achieves positive outcomes for consumers who have received support from peer workers²². Peer work provides an opportunity for people with lived experience recognising their unique skills and experiences to be trained as mental health peer workers. They provide essential support throughout the recovery journey. There is an overwhelming need for people with mental illness or developing mental health problems, and those in crisis to have the opportunity to talk with a peer.

➤ **Recommendation 14.**

- i. Increase the number of peer workers across Australia.**
- ii. Establish and expand the range of services provided and led by peer workers**
Return on investment: \$3.50 for every \$1 invested²³

13 National Mental Health Strategy – Private Mental Health Sector

²¹, *Peer Work in Mental Health*, IIMHL January, 2013

²² RI International, <https://davidwcovington.com/2015/10/22/recovery-innovations-is-now-ri-international/>

²³ Mental Health Australia 2019 Election Platform

The Network has raised many times that the National Mental Health Strategy including the Plans rarely if ever, reflect on the private sector. As a consequence, consumers and carers which our Network represents feel that their mental illnesses don't count, are seen to be less acute, feel invalidated and forgotten. The people obtaining services from mental health settings within the private sector are a significant volume of those seen across Australia. Here are some statistics:

Private Psychiatric Hospital sector

1. Key Statistics regarding Private Hospital-based Psychiatric Services These have been provided by the Private Psychiatric Hospitals Data Reporting and Analysis Service for the periods 08-09, 09-10, 10-11, 11-12, 12-13, 13-14.

- 63 private psychiatric hospitals (as of 2019 there are now 66)
- Approximately 2600 inpatient beds
- 20-22% of the Australian Mental Health Workforce
- Treats in excess of 34,000 patients per annum in the private psychiatric hospitals only.
- (This figure would be far exceeded by those in treatment from office based practices)
- Approximately 16 private hospitals currently provide:
- Community services (former trials known as 'Hospital in the Home')
- Mental Health Nurse Incentive Program

Office Based Psychiatrist sector

In terms of psychiatrist statistical data, the following key findings²⁴ are from the ABS on the use of MBS mental health related services in 2011 the which was published on 24 March 2016. This includes detailed data on psychiatrists and patients' use of MBS mental health services in 2011.

Key findings include:

1.5 million people, 296,400 people or 1.4% of the total saw psychiatrists in 2011 and the average number of consultations was 7.1.

Of all people who had at least one MBS subsidised consultation with a Psychiatrist in 2011, more than half (56.9%) also had at least one prescription filled for antidepressant medications in 2011, one-third (33.4%) also had at least one mental health-related consultation with a GP, and 31.2% also had at least one prescription filled for antipsychotic medications. Around one in five (19.3%) saw a Psychiatrist only, with no other MBS or PBS subsidised mental health-related treatment in 2011.

In addition, the AIHW published 2014-15 data²⁵ on in April 2016. This includes some further useful statistics, particularly of note (in terms of increasing demand/role of the private sector in delivering mental health services):

The total number of Medicare-subsidised mental health-related services increased from 7.7 million services in 2010–11 to 9.8 million services in 2014–15, translating to an average annual increase of 6.0% over the 5-year period to. From 2010–11 to 2014–15, clinical psychologist services had the highest average annual increase (10%), followed by GP services (8.2%) and services by other allied mental health services (7.8%). The number of subsidised psychiatrist and other psychology services increased at a lower rate over the same period (average annual increase of 3.5% and 3.1% respectively).

Office based Psychologist sector

²⁴ ABS data on the use of MBS subsidised mental health-related services in 2011

²⁵ AIHW: Medicare-subsidised mental health related services

Data from the Australian Psychological Society shows that of their members, at least 10,000 are delivering psychology services in private practice. Key findings also include:

Psychologists delivered 4,710,921 sessions of psychological services in the 2015 calendar year.

Psychological therapy is also being delivered in private practice through other funding sources eg.

- Primary Health Networks
- Workcover
- Department of Veterans Affairs
- Victims of Crime
- Client self-funded through their health insurance fund however there is no current data on extent of this work.

Other Office Based Allied Health Professionals

Data made available to the Network shows that Occupational Therapists and Social Workers provided a further

324,760 sessions in the 2015 calendar year.

We do not have data which would define access to mental health nurses, but the Network believes this would be in excess of Occupational Therapists and Social Workers.

General Practitioners

The Network also knows that a great deal of people access GPs for their mental health issues. Many rely on their GPs usually under extended visits, because they cannot access other mental health services.

The data for 2011 from the Australian Bureau of Statistics shows that 1, 244, 900 people in 2011 or 5.7% of the total for an average of 1.8 consultations each saw their GPs for mental health issues. This data can be obtained through the same link as above namely ABS data on the use of MBS subsidised mental health-related services in 2011 which was published on 24 March 2016.

The data provided to the Network shows that a large number of individuals - 1.5 million people (7.2% of all Australians) used at least one MBS subsidised mental health-related service in 2011. These are the latest figures available from the ABS.

➤ **Recommendation: 15.**

Include representation of the private sector should be undertaken at beginning of any initiative relating to the National Mental Health Strategy and any plans beyond the current Fifth National Mental Health and Suicide Prevention Plan including membership of any writing group.

14 Health Insurance Reform

Consumer right to transparency

The Network had representation on the Federal Minister Greg Hunt's Health Insurance Reform Committee – Improved Models of Care Working Group and also the Mental Health Sub-Group.

There has been a great deal of promotion of the categorisation of health insurance products into Gold, Silver, Bronze and Basic and the assumption is held that all costs associated with psychiatry cover for people utilising services from private psychiatric hospitals will be covered if they pay additional premiums under the Gold category.

This will not be the case as the health funds restrictions will still apply which are detailed within the Hospital Purchaser Provider Agreements (contracts). Transparency around the content and health fund requirements of mental health programs is a separate issue and should be addressed accordingly.

The value of health insurance cover for psychiatry is losing its appeal especially when considering the restrictions placed and the conditions under which policies are provided, for example if one has no further need for cover for pregnancy and wishes to delete this from their policy, it also links to psychiatry and that also is deleted.

The Network strongly recommends that private health insurer and hospital arrangements and the HPPAs that place conditions, restrictions or requirements onto consumers and which have the capacity to affect their treatment must be transparent to consumers, carers and their treating psychiatrists to enable fully informed treatment decisions.

A call for greater transparency is a strong recommendation that we make within this Submission to the Productivity Commission. The Network holds grave concerns about variations in treatment requirements across different health funds for the same provider, making product comparison very difficult. The Network does not believe that the current practice of having to approach each treatment provider to determine what is reimbursed by their insurer is an appropriate way to facilitate consumer choice. This practice will remain within the new categorisation of health insurance products.

An example of the need for greater transparency is that current requirements of health insurers on hospitals to ensure consumers participate in minimum hours of therapy and/or group attendance, and how such arrangements vary significantly between insurers and hospitals even within the same jurisdiction. There is an urgent need that all consumers should be able to easily see and compare mental health treatment options by both insurer and provider. Further, the Network strongly believes consumers should easily be able to compare mental health treatment programs and coverage across geographic regions, by provider and by insurer.

➤ **Recommendation 16:**

- i. All health insurers and private hospitals provide a transparent process which allows consumers to compare mental health treatment options at the point of admission to inpatient or day programs**
- ii. All health insurers and private hospitals provide written advice on what conditions, restrictions or requirements they have in place under the HPPAs which will allow consumers, families and treating psychiatrists information upon which to make an informed decision about their treatment.**