
Productivity Commission

Inquiry into Mental Health

This document includes comments received after the Inquiry draft report was released, up until 27 March 2020, for which the submitter gave their approval for use of their comment by the Commission. Comment numbers follow on from those comments received prior to the draft report, which are available separately on the Inquiry website.

Some comments have been edited to remove information which the Commission considered could enable identification of the submitter or a non-public third party individual.

Comments from Mental health workers

23.	<p>As an RN working at an independent school for 10 years, I have personally witnessed the ballooning in mental health needs amongst students over the last decade. There has been a marked increase in students with anxiety, depression, self-harming behaviour and suicidal thoughts. Initially the school employed one RN to man the Health Centre but had no school counsellor (as unfunded to an independent school). Unfortunately it took the suicide of a year 12 student during his HSC period about 6 years ago to push the school into employing a school counsellor (psychologist) part-time. We now have coverage by a school counsellor 5 days a week, but they are fully booked & find their workload ever-increasing. We often have students who need to be escorted around the school by an adult if they wish to leave the classroom for some reason during a lesson, as they are considered high risk to themselves. Speaking personally now, as a parent of a daughter who has experienced increasing anxiety levels since Year 9. She saw the School Counsellor at her public school once that year, but due to the counsellor also being heavily booked, she found it difficult to access her. We tried a different approach, and booked her in for two 1 hour tennis sessions a week. This worked for a time, until increasing pressures of increased schoolwork in senior years meant that she had decreased time to exercise. Her anxiety culminated in panic attacks in May of her HSC year. I would like to note, that once my GP did put a MHTP in place for my daughter, it was extremely difficult to get appointments to visit her external psychologist. The psychologist was also very heavily booked, and although she wished to see my daughter fortnightly, we were lucky get in to see her once a month. I see the report addresses the social and emotional wellbeing of young people, I believe that the physical wellbeing is also of paramount importance and a major influencing factor on social/emotional wellbeing and mental health. Observing my two children throughout their senior schooling years, son finished HSC 2018, daughter 2019 (as already mentioned), I feel that the education system does our young people a major disservice by dropping compulsory PE/Sport from the curriculum in the senior years of schooling. In this digital age of decreased face to face social interaction, and with the increased stressors of the senior years of schooling, this is when the young people need the</p>
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	<p>health benefits & stress relieving effects of exercise in the fresh air the most! It should be timetabled into the school week to ensure it happens. I have observed that boys still tend to be active at Recess & Lunch in their senior years, but girls are more sedentary</p>
24.	<p>With the increasing number of people requiring mental health care whether as in-patients, within the community or family support systems, as a counsellor there is such gap in services that allows us to help those in need. Generally GP's don't refer to counsellors preferring to utilise psychologists, however a multidisciplinary team effort is required to support the needs of each mental health issue. The lack of education available within the healthcare establishment to support staff in providing them with the knowledge & skills that ensures burnout & compassion fatigue are reduced or prevented is paramount. As both a Counsellor & a Clinical Nurse Educator I am endeavouring to bring these to my staff. But it often feels that I am attempting to empty the ocean with a bucket. I am Grief Recovery Method specialist and recent research from the GRM institute (USA) supports introducing community programmes on grief & loss to support people with PTSD. Why is this not being here?</p>
25.	<p>I have worked in the field of mental health for over 40 years including a period of 23 years as an Area Director of Mental Health Services, plus terms as a Local Health District Chief Executive Officer, Chief Clinical Adviser to a Mental Health Commission, Ministerial Adviser and Associate Professor in a School of Medicine and Public Health. During this period I also undertook and led major service reviews in various states and territories often on delegation from Director Generals of Health or Ministers. I remain a clinician. My concern is that the governance of mental health in Australia has failed, leading to little accountability, removal of budget protection and diversion of cash with little or no consequences for the responsible authorities. I am not saying that this is illegal or corrupt conduct as it is permitted within the rules in most jurisdictions due to the failure of the system as a whole to provide proper legislative safeguards, independent service reviews and auditing. Mental health in many instances has become a cash cow propping up cash strapped general health systems and budget overruns in central and regional health authorities. This has led to the erosion of clinical services, particularly community based mental health services such as crisis teams, assertive community treatment teams, and early intervention services. For this reason emergency departments are forced to deal with increasing numbers of people with serious mental illness. It is impossible to guarantee follow up of people discharged from acute inpatient services, thereby throwing the responsibility onto carers, charities, poorly trained first responders and too often the prison system which have become defacto psychiatric institutions. In rural parts of Australia there is too great a reliance on fly in psychiatrists and teleconferencing and competent experienced mental health nurses are disappearing from the field. To rectify this situation governance must be strengthened with a COAG agreed national mental health plan that is targeted, properly funded with comprehensive formative evaluations that</p>

	<p>are published annually by the Commonwealth, jurisdictions and regional health authorities. These evaluations should be enshrined within legislation and include inventories of services provided, budgets and expenditure, staffing numbers by location and discipline. Where funds are removed to resource other than clinical services these should be highlighted, including contributions to regional/area/district running costs, efficiency and productivity savings and cash diversions to other than mental health programs. The dedicated administrative structure for MH at all these levels should be identified including their delegations and reporting lines to ensure there are senior 'champions' to manage and advocate for their program at every level within the health system. Annual independent audit reports of progress should be presented to Parliament.</p>
26.	<p>What about University and Tafe? Mental health and wellbeing counselling services in tertiary education need more funding as well. Counselling in higher education are not meant to be an emergency service nor is it meant to provide long term care but we do, especially in regional areas where the services in the public sector have long waiting periods for appointments. Counselling is meant to be a core service but Counsellors are expected to work on 12 month contracts subject to HEPPP funding or SSAF (adding to an already stressful work environment). The cost of mental health assessments are out of reach for many students (\$500 - \$1000) and without being assessed they are not able to apply for the assistance they need through Disability Services available on campus. These students fail, blame themselves (and not the situation) and fall through the cracks. They don't get the assistance they need to succeed until their situation is utterly desperate or it is too late.</p>
27.	<p>There is barely any mention of psychology or psychologists in the paper . Very concerning given we are some of the key providers of mental health care in this country . And what of the current role of psychologists working in schools ? No mention of them either ?</p>
28.	<p>Your statement on page 27 that occupational therapists and social workers do not specialise in mental health is inaccurate and seems rather a large oversight. There are a many occupational therapists and social workers who specialise in mental health.</p>
29.	<p>If you really want to save money then employ Peer Support Workers. I am a Peer Support Worker. I can' tell you how many times I have provided support to consumers who have been acutely unwell and in highly distressed states and that has meant that they did not need an admission. A few hours of my time at my meager hourly rate has saved my workplace thousands of dollars. In the work that I do I also have another incredibly useful skill and that's knowing how well people are travelling. This ability to identify how someone is means that the team can then intervene and potentially save more money by preventing an admission. More importantly both of these things mean that we are providing support in the least</p>

	restrictive way. And it's much better for consumers to work with someone who can help them make sense of their experience.
30.	I believe that the mental health system needs to more family focused, in particular working with families of procreation. We often focus on families of origin, and forget that consumers will often be parents. There needs to be improved system to identify consumer parents. There needs to be changes to training (tertiary and on-job) for family focused practice. There needs to be improved systems to identify young carers, There needs to be education not just around youth mental health, but also family mental health. Youth mental health services and adult mental health services need to improve communication and partnership to provide whole of family support and care. Mental health services need to improve their relationships with family services and child protection to better support families impacted by parental mental illness. There needs to be 'family in-patient services' as to not be a barrier for parents to access treatment. Everybody is attached to a system and we need to be better at supporting and working collaboratively to care for the consumers and all members of their family
31.	There is a woeful lack of appropriate supported housing for people with severe mental health issues. SRSs are horrible (I have visited a few) and lack staff who are trained in mental health. What we desperately need is supported housing that is permanent, like CCUs (which are unfortunately only short-term). Please provide permanent housing, like Haven House, for those who have severe mental problems, and which are staffed 24/7 by mental health nurses (like CCUs do). Also, we need more Peer Workers with Lived Experience of mental distress to work with people with mental health issues; it's proven to be very effective in decreasing hospitalizations. Moreover, Peer Run residential facilities would be wonderful!
32.	Hi I attended the 4,5 mental health nurse forum with [Chief Mental Health Nurse] at the University of Melbourne yesterday, I am a RN4 as work as the mental health graduate coordinator clinical nurse educator for Latrobe Regional Hospital, [Chief Mental Health Nurse] discussed with the group about the difficulties in recruitment and being able to identify the numbers of nursers working as mental health nurses due to generic registration. [Chief Mental Health Nurse] has suggested that we contact you guys and put forward any ideas we have in regards to these issues. I have spoken to some of my colleagues and these are the suggestions i would like to recommend. Universities to offer a Double degree general/mental health Bachelor of Nursing. Straight Bachelor of Nursing in Mental health. For those who have completed a post graduate qualification in mental health to have an endorsement on their registration. Graduate program to be part of computer match.
33.	In reading the report I was interested in the proposal to offer a three year undergraduate mental health(MH)nursing course. I participated in one of these myself 25 years ago at the commencement of university training for nursing. While it was an excellent course and has enabled me a rich and passionate career, I have some concerns. I believe there is merit in offering various pathways into MH

	<p>nursing and this might suit some on enrolment who know they want to be a MH nurse. However I have am concerned this could eliminate others. Given the comparatively small number of people who know they want to be a mental health nurse vs want to nurse when they commence nursing, I would be concerned that it gives onus for undergraduate nursing courses to reduce the mental health content even further in the three year course. Anecdotally we know that many nursing students discover a passion or interest for MH nursing on their brief MH placement- I would fear that that opportunity might be reduced. I believe that MH nursing courses are expensive to run & generally lower numbers making them unattractive to tertiary institutions. In addition, mental health is everyone's issue and all nurses have to deal with people's mental health and it should not just be put off to the side as a separate issue. There should be a range of pathways into MH nursing but with a base line in good undergraduate comprehensive nursing care. A fault of my MH nursing course was it lacked focus on physical health- which we are now so aware needs more focus for people with mental illness and which undergraduate nursing does better. For too long the tertiary institutions have been able to have a free hand in the mental health content of undergraduate courses with vast variation in quality and content. Basic level requirements/ standards should be set. A third specialist year that nurses can pick an area of interest- ED, Midwifery, MH would be helpful with streams of specialist care training developed. Mental health nurses are not the only specialist care nurses concerned about comprehensive nursing training ill equipping a nurse for any area except generalist training Pathways should also be encouraged for EN to RN progression in MH. Many people come to MH from other life experiences; pathways that support & encourage this could allow people to advance their training in an area they have found a passion in Finally, while the undergraduate training models certainly do need review, I believe that more is needed to develop the graduate level and beyond in MH nursing. Again, it needs standardisation of content, learning needs, identification of what are essential or key qualities for mental health nurses.</p>
34.	<p>I am a university trained counsellor at Masters level and arrived here in Australia 6 years ago having had a busy and successful career in the UK. I worked within a multi professional team of therapists (psychologists, counsellors, psychotherapists, CBT therapists and wellbeing practitioners) in the National Health Service (NHS) providing counselling on a stepped care basis within a deprived inner London borough. Here in Australia appropriately trained, registered and fully regulated professional counsellors have not been integrated into the medical or mental health system despite the huge and desperate need across the country. Counsellors are often available in remote and rural areas as well as in and around the main towns and cities and integrating them into the under resourced mental health and medical framework would help reduce waiting times, human distress and costs. It is difficult to understand the lack of action by government and major stakeholders to instigate what would be the relatively simple task of providing a conduit to bring a fully trained and regulated professional resource to a client population in much need. Please please someone make this happen!</p>

35.	<p>As a Primary Care/NP I see our psychologists, psychiatrists in our area come and go. Our NP MH is swamped and those psychologists that live here have waiting lists of up to a month. I see patients from all the areas above that require initial assessment & ongoing monitoring and I complete that myself as most days there is no one available to refer to. I believe Nurses, Mental health nurses and Nurse Practitioners are in a position to work with these patients. I agree with the statement that often clinicians are the barrier to appropriate mental health care for a patient . Trained clinicians like nurses, nurse practitioners in Primary Practice have the ability to fill this gap, even if it is just someone professional to vent to. Patients with a problem may only require time and listening and this can be filled by Nurse Practitioners and nurses.</p> <p>I agree that accreditation standards should be developed for a three-year direct-entry. Your comment states, IN THE SHORT TERM - in the next 2 years, so that's a total of 5 years to get a system up and running & a nurse trained. I agree with the (undergraduate) degree in mental health nursing, similar to the option already available to midwives. However, the timeframe is too long to wait. The increased workload is now & will be no different in the future, probably even worse & more demanding. Nurses that are able to support the workload are needed now not in 3 years' time.</p>
36.	<p>I have 12 years involvement with a mental health recovery groups and 7 years working in a support coordination role for people with mental illness. I have seen people recover from mental illness to a point where they have more productive, caring and rational lives than many people without mental illness. I have seen people who have been stuck in the MH public system for many years, subject to compulsory and dehumanising medication regimes. I have worked with a 35 year old man for the short time he was out of jail for drug cooking offences who told me, when I asked, that “I started using drugs when I was given Ritalin as a 5 year old and I have been using them ever since”. I frequently ask the MH consumers deemed by the system as “non-compliant” why they stop taking their meds and I have never received an answer that sounds unreasonable to me; “They make my mind like a fog”; “they make me sleep all day”; they give me horrific constipation”; “they make me sexually dysfunctional”; “the drugs don’t stop the voices” (they just stop me talking about them). I frequently ask consumers what one thing would really help them? In one form or another, the repeated response has been; “I’d like the staff to talk to me like an ordinary human being”. “I’d like one person in my life who is not paid to be my friend”. I have worked with fearful families with violent children medicated for AHD type disorders, One family told me that they were told by professionals that they are not allowed to lock their daughter in a room when she “went off” because that was restraint , so they instead would lock the rest of the family in a room while the daughter “went off” and wrecked the place. Another told me they were advised that when their son was “going off”, they should go under the house. Eventually they moved beds under the house and slept there. The son has destroyed 6 TV screens in a year and the parents constantly buy</p>

	<p>new ones because the screen is a “pacifier”. An older son, who had the same problems is now in the public mental health system. I have read the information provided by various anti-psychiatric organisations and individual professionals, including the CCHR response to your report. I have read the PC correction letter on your website disputing one small part of the CCHR response. To my mind, the points made in the CCHR article sum up many of the problems with the system and highlight a viable solution borne out by those who have truly recovered from MI. We no longer tie people to beds, but we control them by using the invisible ropes of pharmaceuticals. That makes us feel better, as the dehumanising fact of the action is not visible. Most of my clients spend most of their days sleeping. Generous support packages from NDIS are useless because the person can’t get out of bed. Please, please do not dismiss the points made in the CCHR report. It may offend psychiatric sensibilities, but there are many reasonable points that merit deep consideration.</p>
37.	<p>I have serious concerns about the psychiatric diagnosing of children. Even if the Commission's recommendation does not anticipate medication of children, the NZ experience shows that this is likely to occur. We have relatively very little knowledge about how the mind develops works, and how psychiatric drugs work, To interfere with the delicate balances of the developing child's mind, will, I believe will be seen from the future as abuse. I am already dismayed to read of the number of children on anti-depressants even though the TGA expressly does not recommend them for children. Given that it is proven that these drugs cause suicidal thoughts in children, I can't understand why there has been no enquiry into their role in the increasing rate of youth suicide? Why do we have a TGA if its recommendations are freely ignored?</p>
38.	<p>Great work accomplished for the Mental Health Draft Report. It truly highlights the importance of wellbeing for Students in every level. I hope the diligence and sincerity of the team's work pay off. Look forward to a healthy 2020!</p>
39.	<p>As a gambling help project officer and working every day with clients with gambling addiction depression and anxiety, I believe that qualified counsellors should be part of the practitioners in the Australian Health Practitioner Regulation Agency (AHPRA). My job is not below any other health professionals. We all have a part to play in the delivery of mental health services. We don’t want to steal the job of psychologists. But we can support them with clients with mental health issues through our counselling and therapeutic support. For example when they are overwhelmed with work, they can refer these clients to counsellor as well. As a private counsellor, I came across few clients who have chosen me for my qualifications and experience as well as being a member of Australian Counselling Association. They have chosen the psychologist who can give a rebate and put them on a Mental Health Care Plan, which counsellors can’t do. So I believe that consumer/clients must be free to choose between a private counsellor who will require a fee for providing services or a public counsellor who can offer consumers</p>

	<p>rebates with Medicare like other mental health practitioners in Australia. I also want to mention the cost to the public due to counsellors not having a rebate from Medicare. Counsellors do not have any rebates available to us beyond what's given by private health insurance. Due to this, clients view counselling services as a significant out of pocket expense. To allow more people access to counselling, it's important that clients be given an option of getting a rebate for counselling services. In the organisation that I work for, we receive grants and funding. So our clients can avail of counselling services for free. But if they had to pay for our counselling services out of their own pockets, then it is not worthwhile for them and not all can afford it. This is why having a rebate for counselling services is important. Finally, I want to mention the lack of a formal registration process for counsellors. Having such a formal registration process is critically important. Right now, we have counsellors who have different qualifications. But unlike psychologists, anyone who has studied counselling in some form can say that they are a "counsellor" and they can do this because the profession is not regulated. I believe this is detrimental not just to the counselling profession but to people looking for a qualified counsellor who might end up seeing someone who is not qualified. I am a member of the Australian Counselling Association (level 4). And I feel confident in my ability to provide a high level of professional counselling service to the client. This is because I have gone through all the required educational and practical training to be a counsellor. But my concern is when clients see someone who is not in the same position as me</p>
40.	<p>To Whom It May Concern I strongly object to the parameters of the current Productivity Enquiry into the mental health of families due to the risk of further pathologising of children, particularly due to lack of concern for the social determinants of health, such as trauma, which should be considered first and foremost. I believe the premise of the study as mentioned in the draft report: that "...if psychiatric treatments were working there would be a reduction in children requiring assistance" shows a medicalised bias. At best it is ill informed and risks excluding the many causes of poor mental and physical health which are social in origin. At worst it is a veiled reach for new populations to treat pharmacologically . Indeed, in the recent New Zealand example, a similar health screening has led to a massive increase in pharmacological treatment of infants. In my view, such a medicalisation of infants risks many harms and future costs to the person as well as to society more broadly, due to confusing health symptoms with psychiatric disorders. Where the premise is purportedly early intervention, the ill effects of applying such a limited scope could be to worsen the situation.</p>
41.	<p>It is of profound concern that in exploring limitations of Better Access there was no discussion of the extremely low rates of access to psychological, mental health nursing or allied health mental health services by older people. Without action to understand why this occurs and what may be done to remedy it, stepped care using evidence based therapies is not a realistic option for older Australians. This reduces their prognosis for recovery, increases their reliance upon psychotropic</p>

	<p>medications and contributes to increasing healthcare costs related to physical health. The only study I could find asking older people suggests they want access to psychological therapies, contrary to the concept of lack of psychological mindedness being the reason for reduced access. This appears to leave cost vs income, identification and referral patterns by GPs and the limited training of many Australian mental health workers in working with older people as likely important factors.</p>
42.	<p>I am providing these comments as a private individual.</p> <p>It was very disappointing to see how little attention was given to older people's mental health in the Productivity Commission Draft Report (October, 2019). Older people (aged 65 years and over) currently make up around 17% of the population, and this will rise to 22% of the population over the next three decades. Throughout the report, terms such as 'prevention' and 'early intervention' were used with either specific or implied relevance to children, adolescents, and young adults, only; and mental illness appeared to be seen almost exclusively through the lens of early-life development, suggesting a lack of appreciation that learning, psychosocial development, and brain neuroplasticity continue across the lifespan. Similarly, much of the report, with its emphasis on parenting, schooling, and work, seems to imply that 'productivity' is the promise of youth that is realised in adulthood - leaving the reader to wonder what the Commission thinks happens in old age.</p> <p>More specifically, the productivity implications of very high rates of social isolation and loneliness in older people, of older male suicide, of depression in older people (particularly women), of carer stress (especially daughters), and of mental health issues associated with the rising prevalence of cognitive impairment, are opportunities for prevention and early intervention that have not been addressed.</p> <p>The concept of the family reflected in the report appears to be focussed on 'parents and children', whilst the number of families with surviving grandparents and great grandparents in Australia is on the rise, as is the number of centenarians. Additionally, the AIHW reports on the health of Australians suggest older people are increasingly living longer in better physical health, which will necessarily challenge traditional assumptions about productivity. Again, the report seemed to lack any forward-thinking discussion of the implications of this.</p> <p>That being said, I would like to commend you on the quality and substance of the draft report, and thank you for your efforts towards improving the mental health of Australians.</p> <p>I hope you find my comments useful.</p>

Comments from Providers of mental health services or supports

19.	<p>I am a clinical psychologist and have been working in the field for about 15 years now. I was so encouraged when I learned psychology service / allied health would be included in the MBS in 2006. I was utterly discouraged when I learned sessions would be slashed to just 10 session per calendar year in 2012. With 10 session clients simply run out of sessions and often cease treatment prematurely. Where I can I continue to see clients at a reduced fee, and if I don't set limits on this it places stress on me financially. The alternative of telling a client you can no see them because these session have run out is equally troubling. Please reinstate the 18/20 session per year limit. As a system it worked relatively well before it was cut back, watered down and restricted to 10 sessions.</p>
20.	<p>Your initiative and the comprehensive report is commendable. The ideas expressed are not new though remain resistant to change at all levels of mental health. The problem begins with our fragmented society where a child starts life with adversity both in and out of control. Government funding is not to blame but it's utilization which must be tested by its proposed outcome. An average person requiring mental health service seldom benefits from the release of funding at the government level. Accessing mental health for a person new to the system is not an easy path. Couple of years ago I needed to arrange urgent care for a family friend whilst I was overseas. Last year I needed to refer a postnatal depression lady to WA mental health system. Both times it was frustrating and time consuming process even for a professional in my position. Public services either were not contactable or had one or other reason not to accept referral. However I was flooded by psychologists services offered at unaffordable costs. Finally I found a personal contact to help me. As life long disorders, illnesses and difficulties start in the childhood, school needs to be the prime target for prevention. Children need to learn life skills and resilience. There should be emphasis on character building from early age. There should be support for the families struggling with children both emotionally and socially. No funding should be allocated to any project without rigorous testing. Both Headspace and Medicare funded psychologists sessions have failed to match the investment in these services. Symptom removal is not the only desired outcome. The comprehensive management must provide occupation, employment, social life and expectation to reach the individual potential. NDIS has been abused widely for non therapeutic expenses. These anomalies are only visible at the grass root level. For example if the NDIS funds are not spent within the specified time it is used by the case managers to take the patient out on a shopping spree. The employment agencies are inefficient as they only record the number of attending clients each day and not the success of finding employment . My patients repeatedly write their resume at these centers each day which goes nowhere There is no formal restriction on using drug or alcohol for a mentally ill person. Involuntary orders only deal with the specified mental illness ignoring the drug and alcohol issue. Once a case manager ignored uncounted cash lying on the table when visiting the patient who was know as drug dealer and a user as he only</p>

	wanted to assess his mental state for preparing his report for the renewal of a community treatment order. Patients prefer to see private psychiatrists for better personal care which is beyond their affordability
21.	Training more psychologists is going to take at least another 4-6 years. Why not utilise accredited and trained psychotherapists and counsellors who are appropriately registered to provide services under the mental health plans just like social workers are able to. Counsellors can bring skills which social workers do and if not more. Telehealth is an option but it's not the same as face to face as so much can be missed. Utilise the workforce already on hand to expand the services to help those in need.
22.	Online support for mental health There is a significant comment in the Mental Health review on expanding online support which is vital in areas that are remote. Of course, access depends on reliable internet access. Additionally this provides support to those who experience issues such as social anxiety that prevent them from accessing face-to-face support. It must be acknowledged however that mental health issues are going to be best resolved through face-to-face support as it is through relationship that we suffer, and through relationship that we can recover. Provide Counsellors with Medicare provider numbers We need to provide easier access to support to those who need it. We need to relax referral criteria in order for patients seeking support from their GP to access the most appropriate support. Counsellors provide valuable support that can at times transcend that which is provided through the clinical and pathological intervention of psychologists and psychiatrists. The majority of clients report the need to have an opportunity to vent their concerns and experience the support of another human being who is impartial, and willing to be present for them. It can be helpful to receive a diagnosis however that is not all of who that person is, and working with a counsellor will support them to highlight their strengths and utilise these to alleviate the symptoms of their condition. Counsellors listed with Medicare provider numbers will provide valuable support to clients. Accessing a psychologist through a GP referral often means the client needs to catastrophise their symptoms in order to achieve the referral. Their integrity is compromised and they may indeed feel worse due to the story they need to provide. If the criteria for this referral is relaxed, the client speaks openly and honestly with their doctor who provides them with the APPROPRIATE referral. The client may need psychological intervention however they may actually benefit more through referral to a counsellor. A recent radio news report stated that only 40% of those gaining a referral to a psychologist or psychiatrist from their GP actually follow through and utilise that support. Based on anecdotal evidence it can be suggested this is due in part to the high cost of the gap fee and / or long wait times for a first appointment. Additionally the limitation of ten sessions for a client to resolve some situations is severely limiting. A client may only need a short period of support however there will be those who require ongoing support over a long period of time.
23.	I would appreciate the opportunity to qualify my comments re MHTP made during my appearance in Sydney to the commission on nov 26th. In line with my comments I believe there is scope to improve the process I would support

	<p>provisional GP referral for a few sessions without a diagnosis Currently plans are comprehensive but could be streamlined and focus on teamwork. I would support MHTP in keeping with stepped care focusing on developing comprehensive assessment by either GP or AHP and collaboration and communication with GP, AHP and psychiatrist similar to new GPEDP recognising complex care coordination/comorbidity. Eg.see example of written plan on following site: https://insideoutinstitute.org.au/medicare/for-gps I also would appreciate consideration of allowing GPs with level 2 training to deliver FPS sessions AS WELL as AHP rather than out of the same allocation as it recognises importance of collaboration eg for eating disorders, complex trauma, personality disorder I think there is need for improvement in communication with patients and psychologists re the important role of GPs in this process rather than “I just need a plan” so it is seen as a collaborative process rather than the GP writing the referral for the AHP to deliver the service. Perhaps both patients and psychologists need to be aware of differences in skills and interests of GPs and encourage better team work. I definitely support increase in numbers of sessions available especially if process of GP review every 10 sessions and mandating better communication - eg letter/contact after assessment and before reviews. And again I would reiterate that the system of medicare rebates being slanted towards shorter consultations mean that it is challenging for many GPs to find the time to do this properly.</p>
24.	<p>Currently completing my training in clinical psychology. Was disheartened to see that existing psychological and allied health services are not being allocated resources to support teams in public mental health. Also, that access/funding for psychologists for general public is not being addressed sufficiently. Who is going to provide ongoing therapy (DBT, CBT, ACT, Schema Therapy, CBT-E etc etc etc not just medical management for those unable to afford private services? 10 sessions is not enough and there is substantial evidence to support this. The K-10 is not a useful outcome measure to assess the use of psychological outcomes/therapies that have been underfunded and thus unable to implement the evidence based treatment models for the length specified... Psychiatrists and mental health nurses are not able to implement evidence based psychological therapies as their training is medically focused but there is an existing psychology workforce that could be used now, people should be able to access this at an affordable price....</p>
25.	<p>Productivity Commission Draft Report on Mental Health October 2019 Dear Sir/Madame, I am a Neurodevelopmental-Behavioural General Paediatrician in Private Practice within a Regional setting. I have 45 years’ experience with a special interest in the area of Mental Health of Childhood and Adolescents and in the process attained a Diploma in Child Psychiatry, Graduate Diploma in Social Sciences (Family Therapy) and lectured previously in Family Therapy for a Graduate Diploma Course. The Commission has documented lack of Mental Health Services and Prevention, and specific to the Medical Profession a disincentive through lack of training, and poor or no appropriate MBS reimbursement – Pages 18, 44, 61, 64. Paediatricians have a high proportion of referrals for evaluation, treatment and support of Behavioural, Learning, Autism Spectrum, ADHD, Intellectual Disability, Anxiety-Depression etc. A Paediatric</p>

	<p>Assessment is a requirement by NDIS, Centrelink, Disability Providers and Education Institutions for a child with a Neurodevelopmental Disability to receive a sign-off and support letter, to attain additional funding for their special needs. Paediatricians are essentially being used within the Australian Mental Health System to supplement the lack of Child & Adolescent Psychiatrists and Child Psychiatric Services. As a Consultant Physician I have no MBS Item number for a Prolonged Consultation, which is a necessity to provide a quality and effective counselling session and ongoing education and support. I have access to an Initial Consultation 132/110 and a Review Consultation 133/116 only, or a one hour face-to-face Family Group Therapy General Practitioner Item number 170, 171, 172 (which I have learned through a Medicare audit is not easily verifiable for a Physician). The Review Item numbers 133/116 available to a Consultant Physician Paediatrician in being used to provide Prolonged Consultations cannot financially sustain a Specialist Tertiary Private Practice. This essentially excludes or at least limits what we Paediatricians in Private Practice can offer as a Mental Health Service Provider and is limiting such a workforce and contribution by interested Paediatricians that could otherwise offer a lot more if such remuneration was more attractive and viable.</p>
26.	<p>Under the heading of prevention and early intervention as a school counsellor I have experienced that a great deal of time is spent on theoretical work rather than practical in schools. There is too much emphasis on report writing based on assessments such as WISC that are time consuming and turn students away. The referrals that school counsellors make to external services like Headspace have up to 6 months waiting period. This is unreasonable given the immediate needs of young people. Mental health services I have worked for and networked with report that funding has cut back the number of staff available to provide counselling. The main feedback from clients and staff is that the introduction of NDIS has changed the face of services. Where once clients were welcomed into a safe space to spend time with other clients or take part in free group programs provided by government funding they are now experiencing a more business orientated approach with a receptionist at the front of office and appointments made for each client. The groups are no longer running as each client has a tailored package. Those who do not meet the NDIS criteria do not know where to go for programs that receive other types of funding and this is because the structure is constantly changing within organisations. The clients who have one on one support through support workers are becoming codependent on support workers for company rather than attending groups where they can meet other clients. The goal of self determinism is idealistic with severe mental illness and support workers have been working with client who did not require support before but under NDIS are having their houses cleaned and taken shopping when they were able to do this before the introduction of this scheme. The idea of being client centred rather than service centred has been problematic as some clients do not have the capacity or capability to make decisions for themselves. This has been handed over to Local Area Coordinators who gather information that may or may not be accurate from clients and their support workers. There are still some gaps in what can be provided to clients who may need to further their education to improve their confidence and participation in the community and employment. Funding has been found not to cover some of</p>

	<p>these requests. There have been many requests at a service I worked in for NDIS to provide counselling. They have been referred to their GP to request a mental health plan and while there are registered providers on NDIS lists it is up to the client to access these without the knowledge of their existence or how to engage with providers. Wait lists for psychologists through the Mental Health plan is long as anyone can access them. There are not enough Non for profit government organisations providing free counselling in Queensland. Severely mentally ill are not monitored so miss pills or don't take them causing them to isolate and become unwell again.</p>
27.	<p>I would also like to add that after clients have been exited from mental health units and no longer on involuntary orders they are free to see their GP and Psychiatrist when they choose. This means that they may choose not to or go to many GP's and add other prescription medication to their anti psychotics that do not interact well and cause behaviour and mood changes that harm themselves and others. I know of one case where a man who has been a commendable tenant with a letter from the property manager advising him of this has then been sent a breach of tenancy because he was causing a nuisance. I later followed this up to find out that he had been prescribed a medication that did not align well with his antipsychotic and had resulted in him abusing people in the community including neighbours, family and his spouse. The lack of monitoring and follow up of severely mentally ill people in the community is resulting in interventions not preventative ways of working with people.</p> <p>Their symptoms untreated escalate rapidly and a 25 year old schizophrenic as shot by Police in an Ipswich train station last year who the primary health care system failed. These individuals need to be monitored regularly and be encouraged to take their medications at the right dosage as many of them reduce their dose or stop taking them altogether believe that they are normal. They have no idea of their mood and behaviour changes impacting on others around them in an adverse, negative and often aggressive way that is further perpetuated by alcohol and drugs putting a strain and risk on Police and Paramedic resources.</p>
28.	<p>I am a general paediatrician working in a regional centre. I work in public inpatients, indigenous and refugee health and private practice. As a general paediatrician I expect that a proportion of my work is in developmental and behavioural paediatrics. The rest would be in children with acute and chronic medical conditions. I had no mental health training during my fellowship. Since graduation, myself and my colleagues have been overwhelmed by the need in mental health paediatrics. Some of these are associated with underlying developmental disorders such as Autism, but a large majority are in otherwise neurotypical children. Anxiety, self-harm, suicidal ideation, school refusal and eating disorders are becoming a prominent reason for referral to all my clinics as well as inpatient admission. In a general paediatric ward we do not have the set-up to give the best care to these children. Myself and my colleagues are treating a prescribing children medication such as anti-psychotics previously only in the domain of a psychiatrist. Specific mental health concerns such as trauma, attachment disorder and PTSD are prominent in the indigenous health and refugee</p>

	<p>clinics. There is minimal appropriate infrastructure for these communities. In fact DHHS involvement or English as a second language often excludes these families from access to both public and private services. Other children with chronic health conditions such as type 1 diabetes also have a significant mental health burden which directly effects their health outcomes. The current mental health services, specifically child and adolescent psychiatrists, are only able to see the tip of the ice berg, meaning that as general paediatricians we are managing these children alone. Furthermore, the general paediatricians in the area are also full and the burden is falling on GPs or being unmet. Finally, as the children reach adulthood it is impossible to find appropriate ways to transition children to adult care. Many are on medications that can only be prescribed by a Paediatrician or Psychiatrist - and there are no psychiatrists, both in public or private, to take on their care. Public mental health is for the most severe cases only. We have one boy in our paediatric refugee clinic with non-verbal ASD that we have been trying to transition to adult care without success for 2 years. He is now approaching 20. There is no service who can take on his care. I cannot see anyway forward except to rethink the entire mental health service. There needs to be care and focus on prevention and lower morbidity aspects of mental health to ensure continued engagement in schooling to ensure the best outcomes for our young people.</p>
29.	<p>1. New migrants in their transition and settlement stage in a new country would be more vulnerable and prompt to develop a mental health issue. Support services for new migrants need to have more elements to promote the psychological and mental well-being among the new migrants and their community. 2. Government's funding to support initiative projects to promote psychological and mental well-being needs should not be short term based. Service continuity will help to develop a better service approach to address the needs and evaluate the intervention. 3. More co-work and collaborative work between universities and service providers and communities would be more cost effective to evaluate services and interventions. 4. Service providers may need to consider the service flexibility such as extending the service hour from 9-5pm, evening service, weekend service will provide options for people who really cannot access service during daytime or weekday. 5. nowadays, IT technology is a good way to encourage young people better to access services in their comfortable way and time, but for those who do not have this knowledge and resources will be benefited. And when people who are being affected by mental health issue, they usually are less motivate to approach services. 6. among the international students, it is advised to strengthen the peer support. to increase students and student leaders' mental health literacy will help to encourage help seeking and awareness on mental health crisis. 7. Older migrants from a CALD background needs more community resources about mental health in their language. More training and support to the leaders and members of CALD senior groups will be helpful</p>
30.	<p>NMHC Is presently unfit for its role. At least 4 commissioners block advocacy for [name withheld] and her son. Unexplained, that supports govt negligence and police hate crimes against psychotic people.</p>

