The Senate Standing Reference Committee on Community Affairs
Commonwealth Funding & Administration of Mental Health Services
Committee Secretary
My (Gabrielle Stephenson) focus is on the universal and selective prevention intervention strategies aimed at avoiding where possible, the onset of mental health problems.
It is not about the relatively few â eligibleâ people needing to fit within an
indicated program but my focus is on broader program issues such as identifying, managing,
monitoring unmet need. The National Mental Health Commission (NMHC) sounds positive
in that area but its proposed role is so far a blank canvas to me. The NHMC may simply add
to a plethora of agencies with no one agency having the much needed global portfolio
responsibilities. It may run parallel to the Mental Health Council of Australia and the recent
National Preventative Health Taskforce. The strategies that arose from the taskforce had only
physical issues on its agenda. Good health must include good mental health.
In looking at mental health problems I go beyond a simple diagnosis to the impairment and
disability that has every potential to disrupt a sufferer's life but does not need to. A â mental
health problemâ may in fact be an undiagnosed mental illness awaiting â earlyâ intervention
processes. In that context, earlier â prevention interventionsâ are predominantly left to the
realm of medical research with no task identified for the general community.
We should be able to look to government for consistent non-ambiguous guidance. In an ideal
world we would all have responsibility for our own actions without the need for government
or taxpayer interventions. But I suspect we get confused between â responsibilityâ and
â consequenceâ . So much so that a recent parliamentary Inquiryâ s report2dealing with youth suicide opened its
chapter on â mental health literacyâ with these words: â Ultimately any discussion about early intervention and suicide prevention involves some responsibility being borne by the person who is experiencing difficulty in seeking help.â
Bill Shortenâ s global-issue article in The Saturday Telegraph 11/6/2011: â â ¦.While the government should not adjudicate every argument - sometimes you need to
take responsibility for your own actionsâ ¦.â . An earlier COAG reported â â ¦.it is not reasonable to expect that everyone will experience good mental health all the
timeâ ¦.â . I am sure every strategy has successes and am optimistic and outcome-program focused. But
as indicated above, I would like to temper that with some caution. â Stigmaâ is a lazy term.
The line between active stigmatising practices and attitudes, and relative ignorance and a
complete lack of concern, is so blurry that anti-stigma advertising received by the

â convertedâ is less effective than it could be. As a personal aside, my own good mental
health is too important to leave to others. I accept the compromises within public funding
and related jumping through hoops are needed and have empathy for those who live it.
And in the overall context, I have not seen a national mental health policy.
Your Inquiry focuses on budgetary measures so within that I limited my focus to what I saw
as prevention elements within the â national mental health reformâ measures. Whether or not
the promise of the budget is realised and 100% of funds remain quarantined for their initial
purpose and whether or not â consumersâ get defined â outcomesâ over five long yearsâ ¦.is
truth-in-waiting.
The health & wellbeing checks for 3 year olds and the research â even within existing
NH&MRC funding - is supported on available information.
RECOMMENDATIONS
Recommendation 1: The NMHC should not be a National Mental Illness Commission by
another name but rather deal with both mental health and mental illness as the peak
authorityâ ¦.with teeth. And it should possibly subsume the MHCA and integrate all other
relevant bodies.
Re ;NMHR - leadership in mental health reform â continuation
Recommendation 2: For all the reasons in the preceding paragraphs, the government, using
a truer and functional version of â whole-of-government processes, should identify what
prevention interventions exist, review for best practice and develop a national mental health
policy. It should seek to publicly rebut WHO comments (co-authored by Australian experts)
cited in the attachment.
Re; NMHR - Better Access Initiative â rationalisation of GP mental health services
â â ¦.The rebates for GP Mental Health Treatment Plans will remain higher for those GPs
who have completed Mental Health Skills Trainingâ ¦â
â The Government will introduce a two tiered rebate for Mental Health Treatment Plansâ ¦.â
Comment: â Consumersâ who ask to be placed on a Mental Health Treatment Plan (MHTP),
rather than await the doctor to possibly think of it, empowers them and enables more fully
informed decisions. This measure could possibly aim to tackle ad hoc treatments, delayed
diagnosis and misdiagnosis as well as possibly providing a financial incentive for the
increased mental health literacy of GPs. But there are contra-indicators.
NOTE: The intention is to SAVE $405.9 million over 5 years
Recommendation 3: An increased uptake of GPs for this training seems a critical issue for

the programâ s success so should be actively pursued. Both the GP training and patient take
up rate should be specifically targeted by the Commission. Any savings could be re-directed
to GP skills training but why savings are indicated is not transparent.
NMHR - Better Access Initiative â rationalisation of allied health treatment sessions
â Under the new arrangements, patients will be able to access up to six subsidised mental
health services through the Medicare Benefits Schedule (MBS). An additional four MBS
subsidised mental health services will be available to patients who require additional
assistance.â â â ¦.The new arrangements will ensure that the Better Access initiative is more efficient and
better targeted by limiting the number of services that patients with mild or moderate mental
illness can receiveâ ¦.â
Re; The intention is to SAVE $176.4 million over 5 years.
This â reformâ seeks to differentiate between mild and moderate mental illness â whatever the
functional definition of those adjectives - and implies it is a more efficient use of allied health
professionalsâ time to await a serious onset of illness. Or for the GP without the mental
health skills training, to change tack midway. Casual or clinical observations? An apparent
â mildâ mental illness running its natural chronic course may have severe episodes. Does the
allied health professional decide not to accept the patient with
â mildâ presenting symptoms?
If either the GP or the allied health professional applied flawed Government assessment
criteria, what was the worst case scenario? That a referred patient had no mental health
problem?
Recommendation 4: When we look at prevention and that nothing we have done so far has
reduced the entrenched risk factor of 20% (of us will endure a mental health problem), this
programâ s funding should not reduce until the NMHC has a chance to do an evidence-based
analysis.
NMHR - expansion of youth mental health
â â ¦to establish 30 new headspace sites, and provide additional funding to existing sites and
the headspace National Officeâ ¦.â
The headspace program provides communityï¿¿based support and assistance to Australians
aged 12 to 25 with, or at risk of, mental illness.â

Gabrielle Stephenson