

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 'eligible' 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 NMHC 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 'mental

health problem' may in fact be an undiagnosed mental illness awaiting 'early' intervention

processes. In that context, earlier 'prevention interventions' 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 'responsibility' and

'consequence'. So much so that a recent parliamentary Inquiry's report dealing with youth suicide opened its

chapter on 'mental health literacy' with these words: 'Ultimately

any discussion about early intervention and suicide prevention involves some responsibility being borne by the person who is experiencing difficulty

in seeking help.'

Bill Shorten's global-issue article in The Saturday Telegraph 11/6/2011:

'While the government should not adjudicate every argument - sometimes you need to

take responsibility for your own actions'. An earlier COAG

reported 'it is not reasonable to expect that everyone will experience good mental health all the

time'. 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. 'Stigma' 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

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 national mental health reform 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 consumers get defined outcomes over five long years is truth-in-waiting. The health & wellbeing checks for 3 year olds and the research 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 authority with teeth. And it should possibly subsume the MHCA and integrate all other relevant bodies.

Re ;NMHR - leadership in mental health reform a continuation  
Recommendation 2: For all the reasons in the preceding paragraphs, the government, using a truer and functional version of a 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 a rationalisation of GP mental health services  
a a |.The rebates for GP Mental Health Treatment Plans will remain higher for those GPs who have completed Mental Health Skills Training |a  
a The Government will introduce a two tiered rebate for Mental Health Treatment Plans |.a

Comment: a Consumers 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 program'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 - rationalisation of allied health treatment sessions

- 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.

- 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 receive.

Re; The intention is to SAVE \$176.4 million over 5 years. This reform seeks to differentiate between mild and moderate mental illness - whatever the functional definition of those adjectives - and implies it is a more efficient use of allied health professionals' 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 mild mental illness running its natural chronic course may have severe episodes. Does the allied health professional decide not to accept the patient with mild 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 program's funding should not reduce until the NMHC has a chance to do an evidence-based analysis.

NMHR - expansion of youth mental health

- to establish 30 new headspace sites, and provide additional funding to existing sites and the headspace National Office.

The headspace program provides community-based support and assistance to Australians aged 12 to 25 with, or at risk of, mental illness.

Gabrielle Stephenson