GIPPSLAND ADVOCATES FOR MENTAL HEALTH INC.

Incorporated Association No A0048721F - ABN No 35 677 151 893

Deductible Gift Recipient **Charity Tax Concession Organisation**

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The Secretary
Senate Community Affairs Committee
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SUBMISSION TO –
INQUIRY INTO MENTAL HEALTH SERVICES IN AUSTRALIA:

1. Gippsland Advocates for Mental Health Inc:

This submission is made by the Gippsland Advocates for Mental Health Inc (GAFMH), an organisation, which is committed to improving the quality of life of those people in the Gippsland region of Victoria who suffer mental illness. A copy of the association's Objects and Statement of Purposes is attached.

GAFMH is a relatively new organisation. The association was established in 2006, following the concerns about mental health services in Gippsland, which were being expressed by a number of people in the region. Membership of GAFMH now stands at 33 persons. The professions/skills of the seven (7) member Committee include Medical Practitioners (2 GP's), A Certified Accountant (Treasurer), the Principal of an employment agency specialising in providing work opportunities for those people with disabilities (Chairman), a Coordinator Indigenous Mental Health Services, a Consumer and an Administrator (Secretary).

General membership of the association includes other GP's, Psychiatric Nurses, Psychologists, Consumers and other concerned citizens with a range of practical skills and experience with mental illness. Management of the association rests with the seven member committee with the Chairman, Secretary and Treasurer acting in the capacity of an Executive Committee. Agencies represented include Lifeline Gippsland Inc, Latrobe City Council, Victorian Mental Illness Awareness Council (VMIAC), Gippsland Accommodation and Rehabilitation Support Services (GARSS).

The association is currently administered by its committee on a purely voluntary basis with general members meeting with the committee each month. The City of Latrobe has provided an office and meeting room facilities to the association on a peppercorn rental and Telstra Country Wide and local business houses have kindly donated necessary office equipment

2. Advocacy:

Given the Objects of our association, we are naturally concerned to improve the provision of advocacy services to those people with a mental illness in this region. The Committee would be aware that Gippsland is a vast region and covers an area of approximately 44,000 square kilometres and comprises a unique blend of socio-economic groups and demographics.

It is therefore not surprising that the region contains many people with a mental Illness who receive no advocacy service provision at all, except from their GP for medication management.

There are a variety of reasons for this deficiency:

- They do not engage with clinical services or the PDRS service system.
- This group of people are still very unwell mentally but not enough to receive clinical case management, or have been exited from the PDRS service system due to being too well in the past and now have relapsed into unwellness.
- Sometimes these people's behaviour's are so disruptive that they have been banned from the PDRS service altogether.
- These people are socially isolated and often do not have positive relationships with their family to fall back on.
- As a result these peoples self advocacy skills are very limited and more often than not they come across as being aggressive rather than assertive, simply because they do not have the appropriate skills.
- Due to their lack of engagement with the clinical and PDRS services these people do not have an opportunity to engage with the Rural Advocate from the Victorian Mental Illness Awareness Council (VMIAC) and during their day to day interactions would not even come across the VMIAC.

The association believes that the Office of the Public Advocate (OPA) and VMIAC are the only two advocacy services that operate within the state of Victoria.

This poses the significant question – Who will advocate for this group of disenfranchised mentally unwell people?

It is submitted that one solution to this problem would be the expansion of the role of the Community Visitor under the OPA system. This would enable the Community Visitor to become an individual advocate for people with a mental illness who do not receive any support services.

The Community Visitor could be re-named the Individual Community Advocate and be located at the site of the local Community Health Centre, where access to the ICA service would be non-stigmatizing. We envisage that the position would be funded at 1EFT per site, with many CHS's employing several people to the team.

While we acknowledge that the OPA is a state government agency, the association is also mindful of the fact that the funding requirement for meeting this need for advocacy services is beyond the state's resources and federal funding will be needed to address the problem. Moreover, it would be reasonable to conclude that the problems experienced in the Gippsland Region of Victoria mirror the same problems in regions throughout Australia.

While the final report of the Senate Select Committee makes reference to *"the need to strengthen consumer advocacy"* (recommendation 3 – 2.6), there does not appear to be any recognition of the role the commonwealth could play in actually funding individual advocacy programs.

It is submitted that the Senate Inquiry investigates funding models, which are capable of delivering the provision of adequate advocacy services to those people who have mental illness and who live in rural and/or remote areas.

3. Medicare Mental Health Schedule Fees:

The reform of *the "Better Outcomes" imitative to include a new set of Medicare mental health schedule fees and rebates for combinations of private consulting psychiatrists, GP's and psychologists"* was a positive one, which has opened the doors for people with mental health problems to access Psychologists. On the negative side however, it is often difficult for many patients to afford the gap payment.

In some cases that have been brought to the attention of the association, patients do not even have the basic $70 which they can claim back from Medicare. Many psychologists do not "bulk-bill" their patients and as the Committee would be aware, the Psychologist Scheduled fee is $192 per hour. The Medicare rebate of $70 and $100 is approximately half or less of this recommended rate.

While some psychologists do not charge the recommended fee, the actual fees charged still result in a gap cost to the patients.

Many psychologists who charge more than the Medicare rebate fee, won't bulk bill for fear of being over loaded with too much of patient consult work.

The association acknowledges that psychological therapy is not purely one to one counselling, but involves much other work that is undertaken prior to and following the clients' attendance with the psychologist. In one particular case study, recently undertaken by the association, the psychologist spent the entire day from 8am to 5 pm contacting current researchers into OCD directly and overseas for latest information on a particularly disturbing problem experienced by a 15 year old client and her mother who is also diagnosed with bi-polar disorder.

All of the research academics, consulted by this psychologist, stated that it was an extremely complex case, which did not fit the current treatment model and they were keen to know about the behavioural strategies being implemented.

The Medicare payment would clearly not compensate the psychologist for the effort by the psychologist in this case to provide the best possible treatment regime for the patient.

An additional cost impost for patients sometimes results from the Medicare system for GP's referral of patients to psychologists for up to six (6) sessions. If it is considered that further consultation with the psychologist is necessary in the treatment of the patient, the patient is required to obtain another referral from his/her GP. In the event of the GP not "bulk-billing" the patient, there is this additional cost to meet not only the gap payment for the psychologist by also the additional "gap-payment" for the further referral for the six additional sessions.

It is submitted that the Medicare rebate be increased to reduce the "gap-payment" burden on those people with a mental illness.

4. Servicing Rural and Remote Areas:

The report of the Select Committee on Mental Health acknowledged "*the difficulty of attracting medical and health professionals to rural areas*" (page 446 – 16.6). This difficulty remains a major problem for those people with a mental illness in Gippsland where there is a critical shortage of psychiatrists to service the region.

There are no private practice psychiatrists to service the region and while the association understands that there are around eight to ten psychiatrists working within the community health system (government), they are not available for public consultation work.

Of the twelve plus psychologists in private practice throughout Gippsland, some only work in their practice one or two days per week. Overall, there are insufficient numbers of psychologists in the region to provide any near an adequate service for those people with a mental illness.

It is submitted that the Committee should investigate the reasons for the shortage of medical health professionals (psychiatrists and psychologists) in rural areas and recommend a program of incentives to attract such professionals to take up practice in regions such as Gippsland.

5. Career Pathways:

Encouragement needs to be given to improve the career pathways for psychiatric nurses who wish to remain as clinical nurses.

The association is of the view that the current career pathways system only provides encouragement for promotion to administrative and non clinical positions. This results in a shortage of trained clinical nurses and/or a disproportionate number of new and/or inexperienced nurses.

It is submitted that the Committee should consult with hospital management, relevant nurse union(s) and training institutions to investigate and report on -

- **A nation-wide recruitment and workforce development program**
- **Further development of Graduate Nurse programs**
- **Senior Psychiatric Nurse and Nurse education programs**

6. Mental Health Plan

GPs are required to conform to a mental health plan in the treatment of patients with a mental illness where there is to be a referral to other specialists caregivers such as psychologists. The association understands that Medicare occasionally audits the GPs to ensure compliance with this and other requirements. Unfortunately, there is anecdotal evidence which suggests many GPs do not conform to this plan correctly, i.e. the requirement to identify an illness, to recommend a treatment regime and for the identification of outcomes from that treatment regime.

It is submitted that often there is no proper record shown of what benefit the patient has received from the mental health plan and the treatment prescribed by the GP. As there is no adequate follow up, there is no way of knowing if the patient is obtaining a benefit from the prescribed treatment.

It is submitted that Medicare undertakes more regular audits of GPs to insure compliance with the mental health plan.

7. Medication:

The association has been told that the cost of medication for the treatment of mental illness is often a burden particularly for those on low incomes. The average cost for a script of drugs to treat mental illness is around $30. Many patients require more than one drug to treat their illness with up to three drugs at a cost of around $90.00 not being uncommon. Patients on low incomes find this a large burden to pay, particularly if a gap payment impost is added for any referral to a psychologist. Multiple prescriptions can also be a burden for patients with health care cards. Many find that the safety net is too high for them to derive much benefit from it.

Some people, who are medicated for a mental illness, have to meet the additional cost of medication for other medical conditions that are often triggered by the drugs they are being treated with for the mental illness. These conditions include diabetes but can also involve various heart complaints as well

In addition to the cost of medication, patients with a mental illness are faced with costs for the monitoring of the mental healthcare program. The other costs involved in this area relate to pathology blood tests and sometimes CAT scans and not infrequently, tests of the heart.

It is submitted that the commonwealth should review the subsidy for medications to treat mental illness with the view to relieving the burden on the poor. It is also submitted that the safety net for medications be lowered.

8. Hearings of the Committee:

The association understands that in conducting its inquiry, the Committee will hold public Hearings around Australia. We believe that there are many people in rural and remote areas, particularly the medical professionals, referred to earlier in this submission, who would find it extremely difficult to travel to state capitals to give evidence to the Committee.

The association strongly urges the Committee to makes a particular effort to hold a proportion of its Hearings in regional centres so that the tyranny of distance does not prevent potential witnesses from appearing.

9. Attachments:

Objects and Statement of Purposes of the Association