blueVoices
Enquiry by the Senate Select Committee on Mental Health

This submission is made to the Senate Select Committee on Mental Health by blueVoices, the consumer and carer arm of *beyondblue: the national depression initiative.* The submission has the full support of the Chief Executive Officer of *beyondblue* Ms Leonie Young.

Background

beyondblue is about to enter the second of a five year funding cycle. *beyondblue* was initially funded by the Victorian State Government and the Commonwealth Government of Australia to put on the public agenda issues in regards to depression, anxiety, and related substance misuse which represent the most prevalent mental health issues in Australia. It is commonly accepted that depression and anxiety will affect 20% of the population, or 1 million people in Australia each year[1]. *beyondblue* now receives funding from the majority of the State and Territory Governments, either financially or through in kind support. *beyondblue* carries out its mission in a number ways, for example, through targeted research (both applied and clinical), consumer and carer involvement, public education and awareness assisting in the destigmatisation of illness.

blueVoices; The consumer and carer arm of *beyondblue*

blueVoices is the consumer and carer arm of *beyondblue.* blueVoices was formed four years ago, after focus groups carried out by *beyondblue* with consumers and carers discovered that there was very little opportunity for consumers and carers to represent themselves on issues pertaining to the experiences which they had incurred as a result of their illness. blueVoices was then established as the national reference group, in order to provide a platform for these consumers and carers. blueVoices has received the full support of the Board of *beyondblue* and has representation in all States and Territories in Australia.

Since the inception, blueVoices represents the voice of people living with depression across a range of important steering committees/agencies [for example the Mental Health Council of Australia – (the peak representative body for the mental health sector in Australia); Better Outcomes in Mental Health Care Committee; the Royal Australian and New Zealand College of Psychiatry community committee; the Victorian Centre for Excellence]

blueVoices provides support and advice and advocacy opportunities to consumers and carers across Australia, and works to ensure that people living with these illnesses are kept informed and updated about key developments, latest treatments, advocacy issues and disseminates relevant research papers. As part of this there is the "Virtual Network", which is an email service which currently has 11,000 subscribers. It is the belief of blueVoices that a better informed consumer and carer base will lead to better outcomes in mental health care.

Management structure of blueVoices

The structure of blueVoices is that of a management committee which comprises of consumers and carers in each State, representing a range of areas. In addition there are a number of subgroups, developed to address key issues in specific areas, with the chair of each of these subcommittees reporting back to the overarching blueVoices management committee, which in turn reports to the *beyondblue* Board.

The Sub-committees which are currently in operation within blueVoices are:-

1. ybblue – a group which focuses on the needs of younger Australians.
2. brightblueVoices - a group which focuses on bipolar disorder
3. beyondbabyblues – a group which focuses on ante and postnatal depression
4. maturityblues – a group which focuses on the needs of older Australians
5. blueboffins – a group which focuses on current research within Australia

This submission to the Senate Select Committee on Mental Health is based on input from the following avenues:

- members of the blueVoices Management Committee and subcommittees
- community consultations (N=75) conducted by *beyondblue*
- Qualitative research conducted in each State and Territory and published in a range of national and international journals and publications.

Through *beyondblue*, blueVoices has focussed much energy and activity on the lived experiences of those with a mental illness and their carers. The outcome of this work is three-fold.

1. blueVoices provides the opportunity for consumers and carers to tell their own stories of their experiences of living with depression and related disorders, including their treatment by health services and the wider community.

2. Promotion of the lived experience enables others to gain insight into the nature and experience of these illnesses, and importantly, identify what role they in the general community can play in assisting persons living with these illnesses.

3. Gaining insight into the experiences of those living with these illnesses has identified key priority areas and strategic direction surrounding the management of these illnesses more effectively in the community.

Key priority areas identified by blueVoices and *beyondblue*

i) ***Lack of awareness and understanding about mental health problems*** in the wider community.

ii) ***Negative perceptions/attitudes (stigma)*** towards those who live with these mental illnesses, often resulting in overt and covert discrimination.

iii) ***Inadequate access to mental health services*** due to insufficient services being available (as the funding of the services would appear to be grossly inadequate by OECD standards) This results in long waiting lists, and the lack of integration of the public and private sector in Australia. This issue is particularly pertinent for those in rural areas whereby the lack of specialist services and/or stigma may prevent individuals seeking help.

iv) ***Discrimination in insurance*** preventing people with common disorders like depression and anxiety from taking out private insurance or resulting in high premiums charged to persons who may have a history of these conditions (even if not a current diagnosis).

v) ***Mental health workforce*** is also falling below acceptable standards, and the attitude of many health care professionals working in the general health system appears to be highly stigmatised towards those persons with a mental illness, who present for treatment especially within the accident and emergency centres around the country.

vi) ***Discrimination in employment*** results from the lack of awareness and understanding about these conditions resulting in discrimination in the workplace, poor management practices, and an inability by organisations to recruit, retain and return employees back to the workplace.

NATIONAL ISSUES

Currently in Australia, each State and Territory has its own Mental Health Act. The differences between the Mental Health Act in some States is minor. However, differences between other States is quite significant. By having a separate Mental Health Act for each State and Territory, treatment orders such as Continuing Treatment Orders (CTOs) and Community Treatment Orders are totally impossible to enforce. There are some consumers who will move around the country in order to avoid treatment. Whilst there may be some argument from some quarters that it is a person’s right to refuse treatment, there is also an equally valid argument that if it were not for the mental illness, the person would not choose to live the life of an itinerant. We believe that the first measure in offering better mental health care around Australia is to have a consistent Mental Health Act in all jurisdictions. This would enable the clients to be handed on from one State to another for mental health care. It would hopefully ensure less breakdown and therefore hospitalisation for clients as they move around Australia for a myriad of reasons.

A consistent Mental Health Care Act in each State and Territory may prevent some consumers from entering the criminal justice system when they are arrested for committing what may be perceived to be an anti-social act. Anecdotal evidence points to the fact that persons with a mental illness are often incarcerated for these acts instead of being treated in a health care setting. It is alarming the number of mentally ill persons who are now treated from within the criminal justice system. In no small measure this change of treatment focus from hospital to the criminal justice system is due to the closure of a significant number of beds around the country, particularly in what were the large mental health care institutions. There is no doubt that a jail is not a place to treat somebody with a mental illness. We would argue that a unified Mental Health Act across jurisdictions, combined with the opening of a large number of beds for acute care would lead to fewer mentally ill persons being incarcerated in the prison medical system around this country.

All of these issues lead to further stigmatisation of persons with a mental illness and this stigmatisation makes their reintegration back into an open society even more complex that it is currently.

We note the excellent system in Queensland known as Mental Health Courts, and would recommend that the Senate Select Committee also review the concept of a Mental Health Court as an alternative to a Civil /Criminal Court, as a way of maintaining mentally ill persons within appropriate treatment programs within the community.

Recommendations

1. That a single National Mental Health Act is legislated around the country.
2. That Mental Health Courts be considered around the country as an alternative to civil court.
3. That the position of the number of acute beds available around the country be reviewed with the view to treating mentally ill persons in a Health Care Setting as opposed to the criminal justice system.
4. That in each State and Territory there is a specialist postnatal depression unit provided specifically to care for families affected by this illness.

EDUCATION

"people just don't understand mental illness, they think it's all just a case of my attitude and that I just need to pull my socks up".

Education is also strongly linked to any anti-stigma efforts which can be made.

Recommendations:

The education we believe that needs to take place is several fold;

1. Education of healthcare professionals at undergraduate tertiary level and continous ongoing professional development in the workplace level. There is no doubt that Universities in Australia, in many disciplines, offer among the best training to be found in the world. However, there would appear to be a lack of consistency with understanding the illnesses from the perspective of the lived experience in most of the tertiary institutions in Australia. blueVoices strongly urges that tertiary education is reviewed in the light of having considerable consumer and carer input into the education program and delivery on mental health subjects. If future graduates and practitioners of mental health care services have a better understanding of the consumer and carer needs from the outset of their training, this will translate through into a superior level of service when they are in the field practicing their professions.
2. There needs to be a significant education of health care professionals in the work force about dealing with persons with a mental health problem and their families. Research and experience has demonstrated to us quite clearly that whilst Australia has a number of very fine practitioners in the speciality disciplines of mental health, there is a large number of persons who come into contact with consumers and carers with mental health problems who have little or no understanding of their issues. Often it is these practitioners that unwittingly <u>enhance</u> the stigma associated with mental illness by their attitudes. Of particular concern is the attitude of staff in accident and emergency centres around the country who in many cases do not view mental illness as a real illness when compared to the other multitude of

physical problems which they encounter on a daily basis. We note that in some sections of the country, there are specialist staff in accident and emergency centres to deal with mental health issues as they arise, and it is very pleasing to note that in the recent past, four staff have been appointed to the Accident and Emergency Centre at the Sir Charles Gardiner Hospital in Perth. We would recommend that these type of services and staff be made available in accident and emergency centres around the country, so that appropriate liaison of mentally ill persons and their carers can be made when they present for treatment at accident and emergency centres. We would further strongly recommend that as part of any education program within hospitals and community health care centres, it is mandated that mental health training is as strongly represented as is the training for medical emergencies and fire. Once again it is our belief that a better educated work force will lead to better outcomes for persons with mental health issues when they present for care.

3. Of particular concern to beyondblue/blueVoices is appropriate education for the General Practice community in Australia. It is a commonly accepted fact that 55% of people who receive mental health care in this country do so through their general practitioner. Of significant concern to us however, is that of those people who present for mental health care through their general practice, only 15% of people receive any evidence based treatment. There is no doubt that the Better Outcomes in Mental Health Care Initiative has encouraged those GP's with an interest in mental health care to further hone their skills in this area. However, reports from research and focus groups would suggest that the standards of general practice still have a significant variation in quality. One of the issues which has been raised consistently throughout the research for many people is the dehumanising effect they feel when visiting their general practitioner, We would strongly recommend that as part of an education model through the Royal Australian College of General Practice, is a program which instructs GP's on how to interact both appropriately and empathicly with clients who present for care through their practice, so

that the presentation for care is not stigmatised and that the client feels safe in returning because they have not had a dehumanising experience with the general practitioner or indeed, any other healthcare practitioner.

4. Recent research funded by the Federal Government and conducted on behalf of the Hammond Care Group in NSW by Professor John Snowdon and Mr Richard Fleming, suggest that up to 50% of people living in Residential Aged Care environments experience significant psychological distress. In reviewing education around the country, we would recommend that a program is funded which offers appropriate education and input into depression and anxiety disorders in older Australians for the many staff who work in these types of facilities. The majority of direct client care in Residential Aged Care is carried out by Grade III Certified Nursing Staff (Assistants in Nursing). These staff often have minimal educational qualifications, and therefore do not have very high levels of knowledge around the areas of depression and anxiety and other mental disorders. This in turn can quite unwittingly contribute to the further deterioration of their clients, instead of assisting older Australians to optimise their level of functionality.
5. Continued education of media professionals in Australia to facilitate accurate and appropriate reporting of mental illnesses and suicide that is non-stigmatising and non-sensational.

STIGMA

" how often do you have flowers and chocolates brought into a psychiatric ward?"

It is the belief of *beyondblue/*blueVoices that stigma is the main stumbling block from preventing the full re-integration and acceptance of persons with a mental illness in the Australian community. Stigma presents itself in a whole range of ways from snide comments about mental illness on national radio, or in the national press, through to the total misunderstandings within communities which lead to persons being alienated from the society in which they live.

There is also significant discrimination within families around mental health issues of a family member, as despite the best efforts of many organisations over lengthy periods of time, the level of understanding of mental health problems is still not of a level that it needs to be in an informed society. One of the reasons for this is that persons with a mental illness do not present with any obvious physical symptoms, and therefore the empathy which is often given to a person with a physical illness is not given to somebody with a mental illness. Many times during our research activities we have heard the expression "Just pull up your socks" as a means of moving forward with somebody with an anxiety or depressive illness. These types of responses are at best unhelpful as they further distress the person who is experiencing the anxiety or depressive disorder, as it is absolutely impossible, when in the grip of one of these illnesses, to get on with life in any sort of normal fashion.

Recommendations

1. Continued support for national community awareness education activities. This needs to focus on the fact that these conditions are illnesses, serious but treatable, and that with appropriate treatments

and supports, people with a mental illness can contribute in the same way that an individual can manage and perform if they have a physical illness.

2. Extension of education programs and campaigns through schools. By impacting upon the thinking of young people in this country, then over the years to come, the stigma experienced by persons with a mental illness will be reduced as we will be having a much better informed youth of this country growing into the adults of the next generation.

YOUNG PEOPLE

The mental health of young people has become an issue of serious concern in recent years due to the increase in the number of young people affected by a rising tide of psychosocial disorder. The cause of this increase remains largely obscure, however through effective program planning we can begin to develop effective intervention strategies. This combined with the fact that most mental health problems manifest themselves in the 15-25 year age group, indicate the point at which intervention needs to occur. The immediate need is to respond with an effective early intervention focus during this critical period of adolescent development.

The need for a new approach to 'youth mental health' is timely given the limitations which exist within both the child/adolescent and adult psychiatry as it applies to young people. Too often young people fall through the gap because they are over 18 and do not have what is considered a 'serious mental illness'. Therefore the mental health problems of most young people in the 18-25 age group largely go either undetected or receive no intervention whatsoever. As a result many of these young people are managed by primary care, youth accommodation and support and the education sector, few of whom have any real expertise in dealing with young people with mental health problems. The situation is not too dissimilar for those under 18 as the Child and Adolescent Mental Health Service is under-resourced to work effectively with both young people and many of the community agencies working with young people in their catchment areas.

It is time that those in the primary care, youth and education sectors were acknowledged and supported for their work with young people with mental health problems. This is particularly true for those in rural and remote areas. We do know that approximately 10% of young people with a mental illness receive treatment from a mental health service .By far, the majority of cases are managed by those in primary care and support services, and even then mental health problems which may be manifest are often not detected. It is this group of professionals who require the necessary training and support to continue their work with this client group if they are to offer an effective and timely early intervention response.

While the general population do not have great confidence in mental health professionals, the stigma of mental illness for young people is even more significant. Young people generally find it quite hard to respond to or discuss the general terms ‘mental health’ and ‘mental illness’, and they often treat the terms as meaning the same thing. This in turn adds to their reluctance to access such services. Many studies in Australia indicate that young people would seek help from friends first before going to see a professional.

Young people are often reluctant to seek help and are discerning with regard to whom they seek help from. How a service orients itself towards young people is critical, particularly for young people who don’t necessarily have a serious mental illness. For those who do have a mental illness, the stigma associated with attending a mental health clinic is significant. This strengthens the argument for maintaining and further developing mental health services with a youth focus, and at the same time ensuring that the primary care, youth and education sectors are resourced and supported to detect and manage the more high prevalence problems like depression which largely remain undetected. One approach to begin to counteract this problem is the need for organisations to undertake mental health promotion strategies which target young people and encourage help seeking.

The current service system is such that a young person can end up with a multitude of workers dealing with a range of problems from mental health or drug and alcohol, to sexual assault or protection and care issues. This is often a cumbersome response to what could potentially be addressed by one key worker, with input from clinicians in their specialist fields. It is important to acknowledge the work undertaken by many front line workers with young people, remembering that these people have been able to successfully engage with that young person and are often in the best possible position to offer effective support and timely interventions.

An intersectoral consultation approach is an innovative model that would build the partnership between mental health and drug and alcohol services, to support and resource community based workers with young people as both an early intervention strategy and to facilitate appropriate crisis management. It is a pragmatic attempt at a solution, acknowledging the very real psychosocial and physical barriers to using tertiary services, and the fact that for many young people, trust rarely extends beyond their generic youth worker. It also acknowledges the resource limitations of tertiary services and the potential for primary care providers in prevention and early intervention. It recognises the wealth of experience which these workers bring in assisting young people, and the fact that there is no clear cut distinction between the 'emotional/behavioral hassles' or the social needs which may require mental health intervention. The difference is one of degree rather than perspective. This model with its emphasis on consultation provides an avenue for collaboration and learning exchange between sectors. The focus is on consultation rather than formal education.

Recommendations

1 Improve resources and support for primary care, youth and education sectors to detect and manage the more high prevalence problems amongst youth like depression

2 Funds be provided by government to build the partnership between mental health and drug and alcohol services to support and resource community based workers with young people, as both an early intervention strategy and to facilitate appropriate crisis management.

DISCRIMINATION IN THE WORKPLACE

"I disclosed to my manager that I suffer from depression and ended up losing my job"

Whilst there is legislation in many jurisdictions around Australia which make it illegal to discriminate in the workplace against a person with a mental illness, we have many examples of where mental illness has been used to prevent a person from receiving employment, attaining promotion, being supported to stay at work or continue being employed.

beyondblue has spent considerable time and effort in putting forward the arguments around the illnesses of depression and anxiety to the society broadly. We believe that the only way to appropriately educate society is to have significant public awareness campaigns around these illnesses that affect one in five Australians during the course of their lifetime, and we will be recommending further public awareness campaigns to once again improve the level of understanding of these illnesses in the community.

As indicated, the workplace is an area where particular stigma exists. In Australia over six million days are lost each year due to depression alone (Ref). In response to this, *beyondblue* has spent considerable effort in its Workplace Program (It's our Problem?) in educating the workplace around recognising, and effectively supporting and managing these conditions to support the individual to access treatment and return to work, and reduce the incidence of extended absenteeism, reduced productivity and ultimately unemployment which can lead to further deterioration of an individual's mental and physical health.

Recommendations

1. That workplace mental health training is mandated to ensure that the workforce is educated on mental illness and how to assist persons who develop a mental health problem within the workplace

2. Workplace law is reviewed with the view to further tightening the laws pertaining to how a mentally ill person is treated in the workforce, especially in applying for a position or applying for promotional opportunity.

PUBLIC/ PRIVATE INTERFACE

"Whether I am treated as a public or private patient depends on the way I am admitted, if I have to go in as an involuntary patient, it's public, otherwise it may be as a private patient"

In Australia there are two parallel systems of care for persons with a mental health issue, that is, the public sector and the private sector. Both the public and private sector offer significant opportunities for recovery for consumers and carers with mental health problems. However, on a significant number of occasions, these two systems appear to operate in total isolation from one another. This can be due to a number of reasons. It appears from our research that in a number of States and Territories, there is a basic ideological difference which prevents the inclusion of the private health care system as part of the overall healthcare model for persons with depression and related disorders.

It is the belief of *beyondblue*/blueVoices that the most beneficial system of health care is one that offers treatment that has integration between the public and private sector, with a strong recognition of the strengths of both sectors. It is our hope that avenues are opened up which allows the purchasing of services from the private sector for some uninsured consumers, and likewise access to public health is more freely available for consumers who take out private health care insurance.

Whilst there is a very strong argument which would be had in all of the jurisdictions around the country, that private health insurance does not exclude consumers and carers from the use of the public system, a strong body of evidence exists which demonstrates quite clearly that if a consumer has private health insurance, they are actively discouraged from receiving any services from the public health care service. Our colleagues from the National Network of Private Healthcare Consumers have made a detailed submission to the Senate Select Committee on Mental Health and we would commend their submission to members of the Committee for serious consideration into this area of the public/private interface.

Recommendation

That in all Australian jurisdictions there is the oppdortunity for a strong public/private interface. This interface would allow for the purchasing of services for persons with a mental illness by the public sector from the private sector, when it was felt by the treating team that this approach would improve the outcome for the consumer.

EARLY INTERVENTION

There is a strong body of evidence which suggests that early intervention is by far the best course of treatment for mental health in any developed nation. *beyondblue*/blueVoices has concerns that early intervention programs are not available widely throughout this country, and would support fully the further implementation of the early intervention model as pioneered by Professor Patrick McGorry at the EPIC program in Victoria.

Recommendation

Availability of early intervention programs in all jurisdictions with ease of access to rural and urban consumers.

FUNDING

“You only get into hospital when you are in a crisis, and then discharged too early when you haven’t fully recovered. I need more support at each end”.

Many consumers and carers have expressed concerns to the authors of this document regarding community services which are available throughout Australia. As with most services, the standard is very variable and in some areas is outstanding. However, a number of areas appear to be significantly lacking. This issue can be brought back to a funding issue. Australia spends less than half of the OECD levels of the health budget on mental health. The average OECD level of mental health spending is 14% of the health budget. However, if one looks across Australia, the range is somewhere between 4% and 7% of the mental health budget. It is one of the great misnomers that community care is cheaper than hospital care. This is not the case. However, there is no doubt that treatment of persons within the community is a much better option than hospitalisation. Early intervention programs and aggressive treatment by community mental health teams will ensure lower hospitalisation rates and enhanced quality of life for consumers and carers. *beyondblue*/blueVoices favours an approach to mental health care funding which is consistent with OECD standards- that is in the Medicare arrangements for funding between the Federal and State Governments, 14% of the health budget be quarantined for mental health care spending, and States should be unable to modify this 14% figure. This money should predominantly be spent on service delivery in the community and not on building bureaucracy or establishing further academic positions than which already exist.

The issues around the review of funding should not just be in direct comparison with OECD countries, and this recommendation of 14% of the health budget being spent on mental health should be taken as the minimal entry point rather than the maximum. The funding needs to be examined in terms of how it is spent within the mental health care system. For example, in Aged Care, there needs to be significant education done into caring for older Australians with depression and anxiety and this has been elaborated on earlier in this document. Of particular concern to us is the funding in rural Australia where services at best are mediocre, and in a number of instances they are non-existent. Funding should be made available not just for institutional based services but a significant portion of funding should be allocated to the funding of community services, outreach services and educational programs within local communities. Groups such as Lifeline for example should be funded significantly to address the mental health activities which they perform. (A survey In 2003 through Lifeline Sydney, found that 72% of the callers had what could be termed as a mental health care problem). There needs to be co-ordination of any funding model so that services do not spring up that replicate each other and compete for the same funding dollar. We believe it is far better to have a fewer number of services where those services cover specific areas of mental health care and offer a high quality service within those speciality areas, rather than a significant number of services all trying to do the same job, but in fact decreasing the pool of funding available for the quality of that particular service.

Our research points out to us that funding should be made available to enhance the level of care offered in the public health care system,that funding should be made available to offer a range of services within the rural setting, that funding should be made available for outreach services, and that funding should be made available to purchase specialist services in the Public Sector from the Private Sector. In combination, these services, with the right level of funding, would offer a minimal standard of excellence for health care standards in this country. *beyondblue*/blueVoices recognises the significant advances in technologies which should enable the use or delivery of better mental health care services. Telepsychiatry is one of the newer technologies which can be used to deliver better mental health care services to rural and remote communities. The use of web-based technologies is also a mode to be encouraged. There are a number of cognitive behaviour therapy programs online to assist people, and whilst these should not be seen as being able to take the place of direct service intervention in rural or remote communities, they can offer a service where none currently exists. Web-based services can also be used to offer education and we cite the *beyondblue* website as well as our virtual network as examples of how technology can be used to increase education and support for persons in rural and remote communities as well as urban communities.

Recommendation

That funding for mental health services is quarantined at a minimum of 14% of the health budget.

BETTER OUTCOMES IN MENTAL HEALTH CARE

"I cannot afford private health insurance so my only option for treatment is medication. I cannot get to see a psychologist (for CBT) at the local hospital or clinic for 8 months…what's the point?"

The Better Outcomes in Mental Health Care Initiative is one of the most significant mental health education programs which has occurred in Australia over the last 10 years. *beyondblue*/blueVoices has been actively engaged with many of the advisory groups, in the planning, design, development and delivery of this national program Further research into the results gained from this initiative is encouraged. Of particular interest to us was the placement of psychologists into large rural practices. Research has demonstrated quite clearly that psychologists offering cognitive behaviour therapy have improved significantly the outcomes for persons with depression or anxiety disorder - often within the space of 6-8 one hour sessions. Currently, many consumers report to us that unless they have private health insurance they are unable to afford the recommended fee of the Australian Psychological Society for cognitive behaviour therapy from a Registered Psychologist. The Better Outcomes in Mental Health Initiative made these psychological services available to people in need of a highly subsidised rate, often as low as $5.00 per hour. *beyondblue*/blueVoices would encourage the further use of these subsidised programs across all areas of Australia, to enable those persons who require cognitive behaviour therapy and who would benefit from this therapy to be able to access it. It is our belief that in the long term, this will lead to a reduction in illness severity; will lead to better opportunities for consumers to return to work, and will lead to better health outcomes in terms of a lesser use of the health care system. Ultimately if implemented appropriately, this system would be self-funding in the reduction of the use of resources in other parts of the mental health care sector.

beyondblue/blueVoices acknowledges the advances made in General Practice in the Better Outcomes in Mental Health Care Initiative, and recommend that in subsequent budget cycles, the level of rebate offered to General Practitioners offering high quality mental health services to consumers was increased even further. There must be a reduction in the incentive to reward doctors for the number of patients they see each hour, when it is widely accepted that the volume of patients seen does not equate to good health care. Ultimately, good health care will reduce the burden of suffering for consumers and will also lead to better health outcomes and more cost effective use of budgetary allocations.

Recommendation

Increase Medicare rebates for General Practitioners through the Better Outcomes in Mental Health Initiative.

CONSUMER AND CARER INVOLVEMENT

"We've been there, we know what happens as a result of the system, We can inform about how to make things better, for consumers and carers"

Consumer involvement is at the heart of every activity which *beyondblue*/blueVoices undertakes.

We acknowledge the significant advancements which have been made over the last 10 years in consumer involvement in mental health care services, but it is of concern to us that this involvement does not go far enough. It is our belief that consumer involvement needs to be acknowledged and encouraged at every level of the health system, both public and private. In the public and private sector, there must be full time paid consumer positions to help guide services to deliver services which are ultimately of benefit to the end users, that is, the consumers and carers.

In all levels of bureaucracy in both the design and delivery of services, there must be ample opportunity for consumers and their carers to offer comment and be involved in the development of the services. It is our belief that with the involvement of the consumers and carers in the design of services, that the services will have a better long term outcome for the persons they are trying to support. *beyondblue*/blueVoices believes strongly that there is a role for direct care by consumers and carers within the mental health care system service delivery model. Our colleagues from the National Network of Private Psychiatric Sector Consumers and Carers have presented a detailed submission around consumer operated services, and again we would commend this paper and submission for the Senate Select Committee for detailed reading on how these services should operate.

As part of consumer and carer involvement in mental health services in this country, it is our belief that all relevant organisations involved in mental health must have on their various committees, consumers and carers to offer input. These positions should be paid, and it is also our firm belief that the time of consumers and carers is equally valuable to that of any other person who would serve on a committee.

CARERS

"We (carers) are the ones who end up with the load once they return home. We need to be kept informed and supported"

Although outside the Terms of Reference on the Senate Select Committee on Mental Health, comment must be made on the role of carers within the mental health care system in Australia. Our comments will address the role of secondary carers in the provision of mental health care services. The role of a secondary carer is defined as a family member, partner, friend, neighbour or paid helper who regularly cares for a person with a mental illness. There is no doubt whatsoever that it is thanks to carers that many consumers of mental health care services can optimise their quality of life, that the strain can be taken off health care services and that the carer assists many clients along the path to recovery. Our research has demonstrated to us that the issue which carers raise most frequently is that of full inclusion in the treatment program of the person for whom they are caring. The laws of privacy in this country are explicit, and are often used by a number of mental health care professionals to exclude carers from the level of information needed by them to be able to assist the persons for whom they are caring. It is our strong belief that if a person has a carer, their prognostic outcome is significantly enhanced over a person who has no visible caring support. Carers receive little or no incentive financially for the role they carry out. It must be stated that many carers do not look for financial encouragement, however, the burden of care on a carer can often lead to them giving up paid employment and suffering a significant lowering of their standard of living. *beyondblue*/blueVoices believes strongly that the role of the carer in this country is indispensable, and would encourage the Senate Select Committee to review how carers are involved in care in Australia. **It is our recommendation** that if a carer is available, they be involved from the outset of treatment, and whilst respecting the privacy of the consumer, that all general relevant information which is needed to be a successful and competent carer, be passed on by the treating health care professional to the carer. Financial support should be made more readily available than the current Carers Pension to enable persons who wish to care for a loved one to be able do so, and to be able to perform this level of care with a level of financial security. Carers also need to be fully engaged within the health care system as previously outlined in the consumer involvement above, and these positions should be paid and full time. There is no doubt that as the consumer is the expert to speak to other consumers on mental health care matters relating to their experience with services, the carer is also the expert person to relate to new carers to advise them of some of the issues they will face, and to support them through some of the trials which being a carer will pose.

An area which often goes unreported is that of the dual role of the consumer/carer. In many families, there are multiple members of that family with mental health issues, and very often a person who is a consumer one day will be a carer the next. This is a very complex role for people to carry through and we strongly recommend that more support is given to consumers who are also carers, and that mechanisms are put in place to educate health care professionals on these dual roles. An issue which has been raised with us in our research is that consumers who are also carers, are often not believed when they are speaking with health care professionals about the person that they are caring for at that particular time. This situation can lead to significant emergencies not being addressed adequately, and health care professionals questioning the credibility of the consumer who is also a carer.

Recommendation

That the role of consumers and carers be fully integrated into the organisation and planning of health services.

RESEARCH

There is a need for more research into mental disorders to understand their causes, how they can be prevented, how to increase awareness and reduce stigma associated with mental illness, and to identify innovative and cost-effective and accessible methods of service delivery, treatment and self management. As is enshrined in the National Mental Health Strategy, consumer and carer participation is vital at every step and stage of the research process including research, design, planning, development, content, topic area etc.

Mental health research is underfunded in Australia. A recent research study commissioned by the Department of Health and Ageing and carried out by The Australian National University (ANU) Centre for Mental Health Research demonstrated, that although they account for 19.1% of the overall disease burden in Australia, mental disorders receive only 8.9% of health research funding.

The study also identified areas that are currently poorly researched although they are judged to be of high priority by stakeholders including consumers, carers, GPs, mental health practitioners and health policy makers. These included depression, suicide and research in community and primary care settings.

Stakeholder groups agreed that there was a need for research on prevention and mental health promotion particularly, and research on psychological and social treatments and mental health services. Consumers and carers placed a high priority on the active participation of consumers in the research process. The authors have concerns that not enough emphasis is placed on the translation of research via dissemination into enhanced clinical practice. There is a tendency for government to fund and disseminate non-evidence based programs while ignoring the uptake and promotion of evidence based programs. There are no funds available to researchers to disseminate best practice. Electronic based programs such as MoodGym and Blue Pages are an example of programs which have demonstrated efficacy to improve symptoms, improve mental health literacy and reduce stigma. However, there is no funding or other mechanism that will enable them to be disseminated in the way a government non-evidence based program may be disseminated.

Recommendations

We recommend that strategies be developed which:

1. Increase the overall funding allocated to mental health research.
2. Increase capacity for mental health research, particularly with respect to prevention of mental disorders, mental health literacy and stigma reduction, innovative service delivery, non-pharmacological treatments and for community and primary care settings.
3. Engage mental health consumers and carers as active participants in the mental health research process and ensure that funding is available to facilitate this engagement.
4. It is recommended that governments identify and disseminate nationally existing evidence-based programs and that resources should be made available to research teams for the dissemination of future best practice programs.

Sources:

1. Griffiths, KM, Jorm AF., Christensen H, Medway J, Dear KBG (2002). Research priorities in mental health, Part 2: An evaluation of the current research effort against stakeholders' priorities. *Australian & New Zealand Journal of Psychiatry,* **36**, 322-326.

SUMMARY

blueVoices is the consumer and carer arm of *beyondblue*. During the last four years, *beyondblue* has had extensive consultation with consumers and carers across Australia in a number of different forums which has led to the formation of blueVoices. This submission to the Senate Select Committee has endeavoured to lay out the main issues of mental health in this country as seen through our membership and through our research experience. Overall we believe that the better mental health care will be able to be offered by

1. Amalgamating State and Territory Mental Health Care Acts across the country, so that there is one Act which will enable better care and consistency for consumers and carers as they move around the country.
2. Increase the level of awareness and decrease stigma of mental health care issues through nationwide education programs
3. Revisit the funding formula on a national level so that a minimum of 14% of the Health Care budget is spent on mental health care services..
4. Extend research and increase education programs with respect to older Australians and their unique particular needs in mental health.
5. Integrate services between the public and private sector in this country to best meet the unmet needs of consumers.
6. Improve level of service in rural communities . through telepsychiatry, web-based services, and the additional BOIMHC components, particularly the allied projects that offer psychological services at affordable costs
7. The enhanced funding model will enable the funding of outreach services and involvement of consumer focussed and driven services across the country to enhance the quality of services which is currently available.
8. Enhancing, supporting and recognising consumers and carers as value-added additional members of the mental health workforce at every level.

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