Productivity Commission Mental Health Review: *Analysis of submissions*

Draft 200320

Contents

Executive Summary

The following report presents an analysis of the 331 submissions made by organisations who responded to the release of the Productivity Commission's Draft Report.

This analysis examines each of the submissions and places them into nineteen categories. In doing so it exposes the failure of those supporting consumers to acknowledge mental health consumers' right to their own representation.

People in locked wards or on forced treatment orders, whose lives are fully controlled by the Health Department, are a community of people with a common experience. These thousands of people must not be disempowered in such a disrespectful way. Only the submission from Justice Action addresses that directly.

Many of these individuals live at the difficult end of the mental health spectrum. Some are disabled with severe and persistent mental illnesses, while others incur episodes of uncertain frequency. As a result, they receive the highest level of interference with their lives. They are generally subjected to chemical restraint, suffer the greatest stigma and have the largest

amount of public funding spent on them. Ironically, their voices are not heard. Clearly the grassroots of mental health have been ignored as beneath contempt, and are not recognised as part of the solution despite their essential involvement. The industry's attitude to these people affects the treatment of less disadvantaged consumers.

It would be clearly unacceptable for workers to be represented by retired workers, and worse if those retirees were selected and paid by the bosses. How could those representatives make any demands for change? That is why there has been no progress in consumers' lives despite the significant funding and general acceptance of the consumer-centred approach.

Some radical changes have been adopted in mental health policies. De-institutionalisation evolved into the 'recovery model', which is in principle, consumer self-determination. Consumer community representation is the policy structure for it to function.

The most affected mental health consumers are entitled to select their spokespeople and be funded to present their community's concerns, interacting with external consumer organisations and others about real situations that affect them. This is a structural change that makes the consumers' voice central to changes rather than only to be interpreted by others. Anything less is a fraud, allowing others to impose their own interests on vulnerable people and dissipating the goodwill and funds that the community gives for the most disadvantaged.

This analysis provides an examination of all organisations' submissions (number ID 574 to 1232 inclusive) to the Draft Report. Critically, this reveals a universal acceptance that consumers and their rights should be essential to the provision of services. Further, we have identified 19 different categories of interest and recorded the significant issues raised by each organisation in up to five different categories. The more frequently a category is raised means the more this category concerns different stakeholders.

Submissions Frequency Analysis Table

In the following data, we determine the key issues using the frequency of concerns raised in each of the following categories (total number of issues raised = 975).

The table below is based on **331** submissions made by organisations with the submission number ID from 574 to 1232 (inclusive).[1] The raw data can be found in the 'Google Sheets' titled "PC SS 20032020". (see footnote 2)

Submission Frequency Analysis Table[2]

Categories	**Frequency**
1. Consumer Community Representation Recognising the right of mental health consumers who are currently controlled by the health department to elect representatives to voice their collective interests throughout all tiers of the mental health system	3
2. Self-Advocacy Allowing individuals to represent themselves	13
3. Consumer Peer Workers Peer workers are health workers employed based on their personal lived experience with mental health. These workers then utilise lived experience to provide more bespoke treatment and rehabilitation.	27
4. Consumer Centred Approach Advocating approaches that treat consumer's needs and ideas as a starting ground for treatment, and a valid source of information on tailoring a treatment model	80
5. Psychosocial Support after Hospital Discharge Support, incorporating discharge environment, socioeconomic support, rehabilitation environment, etc.	101
6. Community Based Approach Concerns the education of the wider community about mental health, including suburbs, businesses and the general public; with aim of de-stigmatising the issue	131
7. Treatment Model/Hospital Environment The process of administering treatments, e.g Medicare rebate, two part model.	111
8. Early-intervention and Prevention Crisis Establishing healthcare and community sector programs aimed at providing pre-crisis interventions. Also creating holistic approaches (health sector, policing, community outreach)	78

[1] N.B. The analysis excludes submissions by individuals and allows up to 5 significant categories of interest.

[2] Available at: <https://docs.google.com/spreadsheets/d/1Jnxcq6afCr_eVmWhzayiUI1SqUPIq_6cbnwOjmBBosY/edit?usp=sharing>

aimed at reducing key factors leading to Mental Health issues, including domestic violence, homelessness, etc.	
9. Alternative to Mainstream Therapy Healthcare treatments which are not part of mainstream health care system (e.g. traditional Indigenous spiritual healing, musical therapy)	20
10. Psycho-social Worker Training Training social workers to be more effective at what they do, ensuring workers are kept abreast of new research and treatments, increased specialisations, more cultural awareness/sensitivity in handling individuals needs	49
11. Factors Preventing Access Barriers to consumers accessing health services, such as financial issues, location issues, overburdening of the healthcare system, etc.	56
12. Additional Funding Organisations suggestions for better allocation of funding to maximise consumer treatment	85
13. Data Collection/Research More research completed in Australia, including new therapies. Also includes suggestions for anonymous data collection to better consumer treatment models, etc.	42
14. Health Worker Support Support for those in the psychosocial sector, including peer workers, and family/friends involved in the treatment of consumers	44
15. Homelessness Suggestions focused specifically on the treatment/prevention of consumer issues relating to Homelessness	18
16. Indigenous Peoples Suggestions focused specifically on the treatment/prevention of consumer issues relating to Indigenous Peoples, including differing needs/cultural practices, barriers, etc.	33
17. Youth/Children Suggestions focused specifically on the treatment/prevention of consumer issues relating to Youth	51
18. Rural Suggestions focused specifically on the treatment/prevention of consumer issues relating to geo-location, as well as the differing needs of rural communities to city communities, specialisations	28
19. Violence Against Women Suggestions focused specifically on the treatment/prevention of consumer issues relating to women	6

Submissions supporting Category 1 - Consumer Community Representation

In this section of the paper, we examine the submissions that had consumer representation as a fundamental consideration.

Submission 918: *Being.*

Being is the NSW peak body speaking with and for people living/with lived experience of mental health issues.

The submission recommends the establishment of a national mental health consumer peak body. The submission voices consumers' concerns that "they want their voices heard independently of others. Inadequate representation can occur when we have differing lenses to an individuals' experiences".[3] This submission is clear evidence of the mental health community's demand for independent representation of consumers' needs. *Being* highlights concerns that care directives are ignored during involuntary treatment, and recognises a need to direct policy towards consented representation.

Submission 928: *Consumers of Mental Health WA (CMHWA) & Being.*

This is a joint submission by *Being* and *CMHWA*, an independent mental health consumer peak organisation in Western Australia.

The submission advocates for a national mental health consumer model that solely prioritises "individual and shared consumer perspectives to support mental health and wellbeing at the personal and community level". It highlights the power imbalance between carers and consumers, which limits consumers' decision-making in regards to their treatment and representation.

The lack of consultation with mental health consumers could greatly impinge upon their rights to independent representation. When vulnerable people's voices are unheard, their needs are not met and their health and general wellbeing are compromised. The submission notes that consumers and carers' rights to independently determine who will represent their views under National Standards for Mental Health Services (2010)[4] affords consumers the right to autonomous representation and

[3] Being, Submission 918 to Productivity Commission, *Mental Health,* 14.
[4] Department of Health, 'National standards for mental health services 2010', *Department of Health* (Web Page) < https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-servst10>.

decision-making: "The potential for harm and impacts on the capacity to be representative of a combined consumer and carer body is reflected in consumer feedback for a national organisation led by and for consumers."[5]

Overall, this submission details the importance of a National Mental Health Consumer Model that "speaks for and by consumers to increase efficiency and effectiveness of the organisation by maximising, analysing and communicating the representative voice of people with lived experience of mental health issues".

Submission 929: *Justice Action*.[6]

Justice Action's submission is focused on three issues of key significance: representation, communication, and choice.

We proposed that the Productivity Commission adopts a model similar to the NSW Inmate Development Committees (IDC) and Aboriginal Delegate system, that which have been used for decades. Consequently, consumers should have self-elected external representatives, and treatment models should centre on these representatives' recommendations. Fundamentally, consumers are entitled by their inalienable human rights to autonomy and independence, especially regarding issues of medication, counselling, education, and legal representation. These rights must be legislated into practice, and be protected.

[5] Being and Consumers of Mental Health WA, Submission No 928 to Productivity Commission, *Mental Health*, 2.
[6] https://www.pc.gov.au/__data/assets/pdf_file/0019/251335/sub929-mental-health.pdf

Common trends in submissions: deficiencies of current system

In this section, we have highlighted data that reflects the overall concerns identified by the submissions:

- Out of the *331* submissions surveyed, *138* held the perspective that the current 'hospital/community-based' approach should be replaced by more consumer-centric reform.
    - These submissions ranged across the categories of consumer centred approach, consumer community representation, self-advocacy, and consumer peer workers.

- About 37% (366 out of 975 supported issues) of all issues mentioned, identified structural community issues both in prevention and rehabilitation
    - These submissions were across the categories of psychosocial support, community based approach, early-intervention and prevention crisis, and factors preventing access

- About 43% (418 out of 975 supported issues) of all issues mentioned, identified structural issues in the existing treatment model including funding, staff training, and attending to patients' needs
    - These submissions were across the category of consumer community representation, consumer peer work, consumer-centred approach, treatment model/hospital environment, alternative to mainstream. therapy, psycho-social worker training, additional funding, and health worker support.

Communication: the right to expression.

A common theme was that the restrictive treatment environment limits consumers' expression of their experience to the community and general public.

The proposal to have computers in rooms similar to the provision for prisoners, empowers consumers with a sense of autonomy and individuality, as well as providing a means of self expression. This lessens their isolation and alienation from the outside world, gives them access to family and their culture, choice of other service providers' support, access to

education and improves their re-integration. This would also give consumers an interactive voice in the community aiding the de-stigmatisation of mental health issues.

Choice: control by consumers of treatment options.

The current system does not properly inform consumers of their possible treatments and does not allow them to consider other options, especially where treatment is forced.

- 21.8% (213 out of 975) of all issues raised, recommend creating a treatment plan suitable to the consumers' needs. (Across the categories of consumer community representation, consumer-centred approach, treatment model/hospital environment, and alternative to mainstream therapy). This includes access to NDIS so that consumers can choose their own psychologist/psychiatrist.

Service providers' obligation to uphold consumer rights.

Forced treatment ignores the needs and desires of consumers; it suppresses their input into their own mental health treatment.

- 13.4% (131 out of 975) of all issues raised, recommend a higher emphasis on consumer-related needs, as well as improving the effectiveness of psychosocial worker training. This can be done by improving staff's cultural awareness and sensitivity towards individual needs. (Across the categories of consumer-centred approach, and psycho-social worker training and consumer community representation).

Service providers need to be more conscious of respecting consumer autonomy.

- 9.7% (95 out of 975) of all issues raised, recommend more consumer autonomy (Across the categories of self-advocacy, and consumer-centred approach).

The current system does not provide enough post-treatment support to consumers once they leave hospital.

- 28.3% (276 out of 975) of all issues raised, recommend improved post-hospital rehabilitation. This encompasses ongoing psycho-social support to consumers, their families/relatives, and improving communities' knowledge on mental health. (Across the categories of psycho-social support, community-based approach, and health worker support)