



Submission

Commonwealth funding and administration of mental health services

July 2011

beyondblue: the national depression initiative
PO Box 6100
HAWTHORN WEST VIC 3122

Tel: (03) 9810 6100
Fax: (03) 9810 6111
www.beyondblue.org.au

Funding and administration of mental health services in Australia

beyondblue: the national depression initiative

beyondblue is pleased to present this submission on the Commonwealth funding and administration of mental health services in Australia, to the Senate Community Affairs Committee. In making this submission, *beyondblue* has focussed on the **high prevalence mental health disorders of depression and anxiety**, the impact on consumers and carers, and areas that are most relevant to our work and research findings.

beyondblue is a national, independent, not-for-profit organisation working to address issues associated with depression, anxiety and related disorders in Australia. Established in 2000, initially by the Commonwealth and Victorian Governments, *beyondblue* is a bipartisan initiative of the Australian, State and Territory Governments, with the key goals of raising community awareness about depression and anxiety and reducing stigma associated with the illnesses. *beyondblue* works in partnership with health services, schools, workplaces, universities, media and community organisations, as well as people living with depression and anxiety, to bring together their expertise. Our **five priorities** are:

1. Increasing community awareness of depression, anxiety and related disorders and addressing associated stigma.
2. Providing people living with depression and anxiety and their carers with information on these illnesses and effective treatment options and promoting their needs and experiences with policy makers and healthcare service providers.
3. Developing depression and anxiety prevention and early intervention programs.
4. Improving training and support for GPs and other healthcare professionals on depression and anxiety.
5. Initiating and supporting depression and anxiety-related research.

Specific population groups that *beyondblue* targets include young people, Indigenous peoples, people from culturally and linguistically diverse backgrounds, people living in rural areas, and older people.

Prevalence and impact of depression and anxiety disorders

Depression, anxiety and substance use conditions are the most prevalent mental health disorders in Australia.ⁱ One in three Australians will experience depression and/or anxiety at some point in their lifetime and approximately 20 per cent of all Australians will have experienced depression, anxiety or a substance use disorder in the last year.ⁱⁱ People experiencing depression and/or anxiety disorders are also more likely to have a comorbid chronic physical illness.ⁱⁱⁱ

Mental illness is the leading cause of non-fatal disability in Australia, and it is important to note that depression and anxiety accounts for over half of this burden.^{iv} Globally, the World Health Organisation predicts depression to become the **leading cause of burden of disease by the year 2030**, surpassing ischaemic heart disease.^v

Mental illness costs the community in many different ways. There are social and service costs in terms of time and productivity lost to disability or death, and the stresses that mental illnesses place upon the people experiencing mental illness, their carers and the community generally. There are financial costs to the economy which results from the loss of productivity brought on by the illness, as well as expenditure by governments, health funds, and individuals associated with mental health care. These costs are not just to the health sector but include direct and indirect costs on other portfolio areas, for example welfare and disability support costs. **It is estimated that depression in the workforce costs the Australian society \$12.6 billion over one year, with the majority of these costs related to lost productivity and job turnover.**^{vi} The individual financial costs are of course not exclusively borne by those with mental illness. It is often their carers who experience financial hardship due to lost earnings, as well as increased living and medical expenses.^{vii} It is also important to recognise the differences in mental and physical disabilities, and the impact on workforce participation. In 2003 **28.3 per cent of people with a mental illness participated in the labour force, compared to 48.3 per cent of people with a physical disability.**^{viii}

beyondblue's response to the Commonwealth funding and administration of mental health services in Australia inquiry

A. The Government's 2011-12 Budget changes relating to mental health

The Government's 2011-12 mental health Budget announcements have the potential to significantly improve access to mental health services and outcomes. It represents a significant investment to support the prevention, treatment and management of depression and anxiety disorders. The introduction of the national mental health commission provides a mechanism to increase the transparency and accountability of the system, which may lead to improved efficiency, effectiveness and innovation within the sector. This also has the potential to support a stronger whole-of-government approach to mental health care and ensure that mental health policies and programs are founded on a strong evidence base. To realise the potential benefits of the changes, it is important that the implementation of the Budget announcements are well monitored and measured. This will help to determine the impact of the changes on mental health outcomes, and additional areas for reform.

Recommendation

1. Develop mechanisms to monitor the implementation of the Budget changes and the impact on mental health outcomes.

B. Changes to the Better Access Initiative, including:

- i. The rationalisation of general practitioner (GP) mental health services; and**
- ii. the rationalisation of allied health treatment sessions**

The rationalisation of GP and allied health services through the Better Access program is justified. It enables the redirection of funds to other mental health programs and services, which focus on prevention, early intervention, and increasing access to services. While the Better Access evaluation did demonstrate that the program is effective, it also suggested that service usage from hard to reach population groups (for example, young people; men; and people living in low socioeconomic areas and rural areas) is comparatively lower than other groups.^{ix} A more targeted approach for vulnerable populations is therefore warranted. Rationalising the Better Access program enables the funding of other effective initiatives, which focus on these high risk and hard to reach population groups.

- iii. The impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs**

The introduction of a time-dependent rebate for the development of mental health care plans is an appropriate change.^x This will ensure that GPs are remunerated for the time involved in conducting a clinical assessment and preparing a care plan. Continuing to offer financial incentives to GPs to complete mental health training will also promote patients access to best-practice, evidence-based care.

While a time-dependent rebate is appropriate, the diagnosis and treatment of mental and physical health conditions should attract the same rebate. The Better Access rebates should therefore be equivalent to the chronic disease management rebates. The chronic disease management care plans should also include mental health screening, to ensure that co-existing depression and anxiety disorders are identified and treated.

- iv. The impact of changes to the number of allied health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule**

The majority of people with depression and anxiety seeking treatment through the Better Access program will not be impacted by the reduction to the number of allied health services. The Better Access evaluation found that 75% of consumers received 1 – 6 allied health sessions, 20% received 7 – 12 sessions, and 5% received 13 – 18 sessions.^{xi} The reduction in the number of sessions available from 12 to 10 will therefore not impact a large number of consumers. It will also enable the funding of alternative early intervention and treatment services, which target population groups who are not well served through the fee-for-service model.

Recommendations

2. Maintain the proposed rationalisation of the Better Access Initiative, to enable funding of other effective prevention and early intervention initiatives, targeting high risk and hard to reach population groups.
3. Provide equivalent Medicare rebates for mental health and chronic disease management services.
4. Include mental health screening in the chronic disease management care plan requirements.

C. The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program

The expansion of the Access to Allied Psychological Services (ATAPS) program has the potential to facilitate improved access to early intervention and treatment services by population groups not well served by the Better Access model. While enhancements to the administration of ATAPS are required,^{xii} evaluations of the program have demonstrated that people with depression and anxiety achieve significant positive clinical outcomes.^{xiii} The model also provides an opportunity to trial innovative service delivery models, such as telephone, video and web-based services, to support access to care for hard to reach groups.^{xiv,xv} The extension of the program, to reach an additional 185,000 people over five years, is an appropriate and adequate investment in this model of delivery. It will help to promote collaborative care and support consumers to access effective treatment services; it will support administrative improvements to the program; and it will enable additional mental health funding to be invested in other targeted treatment services (for example, *headspace* and community mental health services).

Recommendation

5. Extend the ATAPS program as planned, to reach an additional 185,000 people over five years.

D. Services available for people with severe mental illness and the coordination of those services

People with severe depression and anxiety require co-ordinated clinical and non-clinical care on an ongoing basis. The proposed single assessment and point of contact process, in addition to further funding for *Flexible Care Packages*, will help in the development of integrated referral pathways. This will ensure that consumers receive wrap around community-delivered support services, that are developed on an individual and as needed basis.

The range of services available to support severe mental illness should also incorporate the needs of carers. Carers provide essential support to people with severe depression and anxiety, and they require high quality and sustainable care and support. This will ensure that they can continue to fulfil their role in assisting consumers to access referrals and treatment; liaising with service providers and assisting in coordinating care; and providing non-clinical support services.

Recommendation

6. Extend the scope of services available for severe mental illness to include the needs of carers of people with depression and anxiety.

E. Mental health workforce issues, including:

- i. The two-tiered Medicare rebate system for psychologists
- ii. Workforce qualifications and training of psychologists
- iii. Workforce shortages

The capacity of the mental health workforce needs to be strengthened to increase access to specialist services in rural and remote communities and to better support other disadvantaged population groups. There is a national shortage of clinical psychologists^{xvi} and the model of health professionals visiting rural and remote communities, rather than being based in communities on a permanent basis, contributes to a lack of ongoing and coordinated mental health services.

To address mental health workforce shortages, particularly in rural and remote communities, it is important that there is a focus on the role of service coordination and integration. *beyondblue*, the Australian General Practice Network and Divisions of General Practice implemented the *Mental Health in Drought Affected Communities Initiative* from 2007 – 2011. This Initiative aimed to develop community capacity and resilience in drought affected communities. Central to the success of this program was the role and function of Community Support Workers (CSWs), who were based in the Divisions of General Practice and performed outreach services; networking and brokerage between service providers; and crisis intervention. The Evaluation of this Initiative concluded that *“The role of the Community Support Worker has been fundamental to building awareness and creating greater access to mental health information, training and support services to organisations, businesses and individuals experiencing or at risk of environmental threats, such as the drought.”*^{xvii} Strategies to enhance the capacity of the mental health workforce should therefore focus not only on clinical service delivery, but also on improving service coordination and integration.

There is also a need to better support the mental health workforce to work with disadvantaged population groups, including Aboriginal and Torres Strait Islander communities and Culturally and Linguistically Diverse (CALD) communities. The Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework recognises the need to build the capacity of this workforce in order to meet the requirements for closing the gap in health outcomes between Aboriginal and other Australians.^{xviii} There is a shortage of Aboriginal health workers and a high turnover of staff in this profession. Additional support mechanisms are needed to support the development, growth, and ongoing sustainability of this workforce. Health professionals working with Aboriginal and Torres Strait Islander communities and CALD communities also need to be up skilled to ensure that they understand different views of health and wellbeing, and specific issues which may impact on mental health problems and help seeking (for more information, see response to Terms of Reference F i and ii).

Recommendations

7. Support the development of service coordination and integration roles within the mental health workforce, particularly within rural and remote communities.
8. Increase the number of Aboriginal health workers and develop mechanisms to support this workforce.
9. Up skill the mental health workforce to better understand issues associated with depression and anxiety in Aboriginal and Torres Strait Islander communities and CALD communities.

F. The adequacy of mental health funding and services for disadvantaged groups

Additional mental health funding and services are needed to target disadvantaged population groups. People from disadvantaged communities are more likely to experience poorer mental health outcomes, lower levels of access to mental health services, and other co-morbid conditions. Ethnic and race-based discrimination is also likely to affect people from CALD communities and Aboriginal and Torres Strait Islander people. This has a negative impact on health and wellbeing, in particular, mental health.^{xix} Targeted strategies, which address the factors influencing mental health and wellbeing; mental health literacy and stigma; and access to healthcare; are therefore needed.

i. Culturally and linguistically diverse (CALD) communities

People from CALD communities may experience significant levels of psychological distress, particularly related to war and conflict, and the disruption of being separated from family and friends.^{xx} Approximately 25 per cent of refugees have been physically tortured or have experienced severe psychological violation prior to arriving in Australia.^{xxi} The resettlement process may also impact on mental health and wellbeing.^{xxii}

The current programs and services for people from CALD communities pose significant barriers to seeking help for mental health services. For example, free translating and interpreting services for allied health treatment are not available through either the Better Access or ATAPS programs.^{xxiii} This prevents people with low English proficiency from accessing mental health treatment and support. Other barriers to accessing services include:^{xxiv}

- stigma associated with mental illness
- lack of knowledge about available services
- GP referral patterns
- cost of services
- language and cultural barriers
- differences in cultural explanations and perceptions surrounding mental health.

Targeted strategies, which address these barriers to seeking help, are needed to ensure that people from CALD communities can access mental health services.

Recommendations

10. Provide free translating and interpreting services for allied health treatment through the Better Access and ATAPS programs.
11. Develop targeted mental health programs and services for people from CALD communities, which address the barriers to seeking help.

ii. Indigenous communities

Aboriginal and Torres Strait Islander people experience significant levels of psychological distress - nearly one-third of Aboriginal and Torres Strait Islander adults report high / very high levels of psychological distress, which is more than twice the rate for non-Indigenous Australians.^{xxv} High and very high levels of distress are also associated with other poor health outcomes and risk factors, including smoking, drinking alcohol at high-risk levels, using illicit substances, and being a victim of physical or threatened violence.^{xxvi}

The determinants of poor mental health in Indigenous communities include a complex interplay of social, cultural, historical, economic and environmental factors. Risk factors specific to Aboriginal and Torres Strait Islander people's wellbeing include discrimination and racism, stressful life events and conditions, widespread grief and loss, child removal and unresolved trauma, cultural dislocation and identity issues, economic and social disadvantage, physical health problems, incarceration, violence, and substance use / abuse.^{xxvii}

In addition to the complex factors contributing to poor mental health in Aboriginal and Torres Strait Islander communities, there are also significant barriers which impact on seeking help for mental health problems. This includes issues such as:

- Health professionals and services not understanding the Aboriginal holistic view of health, which incorporates the social, emotional, spiritual and cultural life of people and the community.^{xxviii}
- The shame and stigma associated with seeking services for mental health problems. This may contribute to a reluctance to seek help, which may be heightened by a lack of confidentiality within the community, and the need to seek support from a mental health-specific service. This reflects problems associated with the compartmentalisation of the Australian health system and services.
- Some mental health referral pathways and practices are culturally inappropriate and do not meet the needs of Aboriginal and Torres Strait Islander people.^{xxix}
- The values and assumptions of health professionals, which may impact on their ability to understand and appreciate the factors impacting upon Indigenous health, and may influence their interactions with Aboriginal and Torres Strait Islander people.^{xxx}

The high prevalence of mental health problems in Aboriginal and Torres Strait Islander communities, together with the complex determinants of health and wellbeing and the barriers to seeking help, suggest that current mental health funding and services are not

adequate. It is well recognised that existing services and approaches have not been successful in improving mental health.^{xxxvi}

To improve mental health and wellbeing in Aboriginal and Torres Strait Islander communities, mental health policies, programs, and funding need to support the development of cultural competence in health services. Such services and providers would have the knowledge, skills, attitudes and values necessary to effectively work within diverse social, cultural and organisational contexts.^{xxxvii} There is also a need for initiatives that build linkages across services and develop local partnerships to ensure there is an integrated approach to care, as well as a greater investment in prevention and early intervention services which focus on improving social and emotional wellbeing.^{xxxviii}

Recommendations

12. Develop and implement policies and programs which address the determinants of mental health and wellbeing in Aboriginal and Torres Strait Islander communities.
13. Invest in mental health promotion, prevention and early intervention services, targeting the Aboriginal and Torres Strait Islander community.
14. Promote and support the development of culturally competent health services.
15. Support initiatives that build service linkages and local partnerships.

iii. People with disabilities

There are high levels of psychological distress among people with a profound / severe disability - 37.8 per cent of people with a profound / severe disability experience high / very high psychological distress, compared to 6.3 per cent of people without a disability.^{xxxix} There are complex factors contributing to these high prevalence rates – for example, people with an intellectual disability may have a poorer ability to manage stress through reduced cognitive and expressive functioning, and continuity of care is difficult with the high staff turnover rates of disability workers.^{xxxv}

Depression and anxiety disorders also result in significant levels of disability. People experiencing depression report having 11.7 ‘disability days’ per month, in which they are completely unable to carry out, or have to cut down, on their usual activities due to their health.^{xxxvi} People experiencing anxiety disorders also report having 9.2 ‘disability days’ per month.^{xxxvii}

The introduction of the National Disability Insurance Scheme (NDIS) provides an opportunity to significantly improve the mental health treatment and services available for people with a disability. For the Scheme to be successful, it is essential that it:

- includes mental health functioning and cognitive and emotional limitations in the eligibility criteria and assessment process
- promotes collaborative team-based care between disability and mental health service providers, through system-level initiatives
- delivers co-ordinated and holistic care, through case managers / care coordinators working across the mental health sector and the NDIS

- includes psychological support needs, as well as physical needs, for both the consumer and their carer
- up skills staff working in the disability sector to understand and respond to mental illness.

Recommendation

16. Improve the mental health services available for people with disabilities by incorporating depression and anxiety disorders in the scope of the National Disability Insurance Scheme

G. The delivery of a national mental health commission

The introduction of a national mental health commission provides an opportunity to improve the transparency and accountability of the mental health system. This may result in significant improvements for people with depression and anxiety and their carers, due to the ongoing focus on the adequacy of mental health services and the need for efficiency, effectiveness and innovation within the sector. The commission will also play an important role in strengthening the use of evidence in the development and delivery of mental health policies, programs and services, and establishing systems for the ongoing monitoring of outcomes.

The commission may also provide an opportunity to build a whole-of-government approach to mental health and wellbeing, and incorporate mental health into other policies and programs, both within the health sector and more broadly. This may enable a stronger focus on the determinants of health, and support the implementation of a collaborative and multisectoral approach to improving mental health.

Recommendation

17. Support the national mental health commission to improve the transparency and accountability of the mental health sector, and to advocate for the inclusion and consideration of mental health issues in all government policies and programs.

H. The impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups

Online services offer significant potential to improve mental health outcomes. Research suggests that the internet can be an effective medium to deliver interventions which aim to reduce the symptoms of depression and anxiety disorders, achieving effect sizes equivalent to those in primary care settings and through antidepressant medication.^{xxxviii} Online services therefore provide an opportunity to increase access to care for people who may not use traditional services due to stigma, cost, geography, or other barriers.

Christensen and colleagues (2010)^{xxxix} suggest a number of expected benefits of e-mental health services, which include:

- providing better access to mental health programs

- rationalising mental health services to match patient need
- fostering pathways to face-to-face professional care and peer-to-peer support
- facilitating continuity of care and follow-up
- providing lower cost treatment options and improving the cost effectiveness of services
- reducing the demand on the workforce
- reducing the burden of disease.

The benefits and effectiveness of online services suggests that this delivery medium could provide significant benefits for people living in rural and remote locations, and other hard to reach groups. To be successfully implemented, system-level mechanisms are needed to support and facilitate the use of services (such as the recent introduction of Medicare rebates for consultations with psychiatrists delivered via video conferencing). It is also important that online services can be integrated and complemented by primary mental health care services.

While online services may offer significant benefits to people with depression and anxiety, the barriers to using such services also needs to be recognised and addressed. Hard to reach groups may be less likely to have access to a computer and the internet, and may have lower levels of ehealth literacy. Education and awareness campaigns to increase ehealth literacy, and targeted strategies which address barriers to using online services, may also be required.

Recommendations

18. Develop system-level mechanisms to support and facilitate the use of online mental health services.
19. Integrate online therapies with primary mental health care services.
20. Develop targeted strategies and education and awareness campaigns to increase ehealth literacy and overcome barriers to accessing online services.

I. Any other related matter

Vulnerable population groups

Additional mental health funding and services are needed to support vulnerable population groups. While the needs of Aboriginal and Torres Strait Islander communities, CALD communities and people with a disability are examined through this current Senate inquiry (Terms of Reference f), it is important that other population groups which are vulnerable to poor mental health due to discrimination and marginalisation are also considered. This includes the gay, lesbian, bisexual, transgender and intersex (GLBTI) community.

GLBTI Australians face discrimination including verbal and physical abuse, which places these populations at a higher risk for poorer mental health than heterosexual people. While many same sex attracted, gender or sex diverse people don't experience depression or anxiety, a number of studies have found that there are increased risks of developing

depression and anxiety, substance use disorders or self harm and thoughts of suicide, and this is strongly related to abuse and discrimination.^{xi, xli, xlii}

Homosexually-active women are more likely than heterosexual women to have experienced depression during their lifetime,^{xliii} and homosexually-active men are much more likely to report an experience of depression in the last 12 months than heterosexual men.^{xliv} The incidence of mental illness in bisexual people is even higher than homosexual people,^{xlv} and Australian surveys have reported that around 50 to 60 per cent of transgender people, and around 60 per cent of intersex people, report experiencing depression.^{xlvi}

The increased rates of depression have been associated with being subject to emotional and/or physical abuse. In an Australian study, 61 per cent of young non-heterosexual people reported experiencing verbal abuse related to homophobia, 18 per cent reported physical abuse and 26 per cent other forms of homophobic discrimination.^{xlvii} School was a common setting for such discrimination and abuse with 80 per cent of young people naming school as a place where they had experienced discrimination or abuse. The same researchers found that the experience of homophobia and abuse was related to feeling unsafe, substance use (including self-medicating substance use), self harm and suicide attempts, and for more than half the young people homophobia impacted on their school careers.^{xlviii} A survey with transgender Australians and New Zealanders has also found that almost 90 per cent had experienced at least one form of stigma or discrimination, including verbal abuse, social exclusion, physical threats and violence.^{xlix}

The recent announcement by the Minister for Mental Health and Ageing that the Commonwealth Government will provide an additional \$1.1 million to the LGBTI Alliance to address mental health and suicide prevention in the GLBTI community is a welcome addition to improving mental health outcomes in this community. To be successful, it is important that this initiative is supported by a whole-of-government approach, which focuses on reducing the discrimination experienced within the GLBTI community. A long term, multisectoral strategy is needed.

Recommendations

21. Partner with the Australian Human Rights Commission, the Australian Federal Police and their state and territory counterparts to eliminate discrimination on the basis of sexual orientation, gender identity or sex.
22. Invest in anti-discrimination initiatives targeting school communities to improve the mental health and safety of young GLBTI people in schools.
23. Support training and professional development across the mental health sector to develop services that are culturally appropriate for GLBTI populations with an emphasis on ending the discrimination GLBTI populations can face at the point of care.

National Perinatal Depression Initiative

In response to the high prevalence of depression, anxiety and the more severe mental health disorders during the perinatal period (pre and postnatal), *beyondblue*, together with the Commonwealth and all State and Territory Governments, is implementing the National Perinatal Depression Initiative. This program includes:

- a national framework for comprehensive psychosocial assessment and early intervention programs for *all* pregnant and postnatal women in Australia
- national guidelines for screening
- workforce training and ongoing professional development for health professionals
- the provision of clear pathways to care for *all* at risk pregnant and postnatal women
- the broad dissemination of health promotion messages to raise awareness and reduce the current stigma across the community
- research and data collection.

While this Initiative will contribute to improved outcomes for women with perinatal mental health disorders and their partners, additional funding is needed to support the ongoing implementation of the Initiative. There is a risk that screening, assessment and treatment of perinatal mental health disorders will not be implemented as a routine component of care beyond the current term of funding (to 2013), unless sustainable systems and structures are funded and developed. The referral rates and demand for mental health treatment services is also expected to increase as a result of the routine screening and psychosocial assessments that are being implemented through the Initiative. It is therefore imperative that there is a greater investment in mental health services, to meet this demand, coupled with efficient data collection, monitoring and evaluation, to inform service delivery and the effectiveness of the Initiative.

Recommendations

24. Fund the ongoing implementation of the National Perinatal Depression Initiative.
25. Provide additional funding for perinatal mental health services, to meet an expected increase in demand for treatment, resulting from routine screening and psychosocial assessment.
26. Provide clear pathways to care for perinatal mental health services across Australia, as stipulated in the perinatal Framework.
27. Establish systems to enable national data collection, monitoring and evaluation.

Stigma and discrimination

People living with depression and anxiety and their carers continue to experience significant levels of stigma and discrimination. Since 2000 *beyondblue* has invested funding in community awareness activities and campaigns. Both independent and *beyondblue*-commissioned research has demonstrated significant improvements in awareness levels and understanding of depression and anxiety disorders over this time (for example, 49 per cent of respondents to the *beyondblue* Depression Monitor survey identified depression as a major mental health problem in Australia in 2002; this increased to 61 per cent in 2009/10).¹

Despite improvements in awareness levels, there are still consistent reports of consumers and carers experiencing stigma and discrimination related to depression and anxiety.

Recent *beyondblue*-commissioned qualitative research exploring the stigma associated with depression and anxiety suggested that stigma has an ongoing negative impact on both family and work life. For example:

- *“...often the ignorance is from those closest to you rather than the actual community. Some of my family members are very patronising.”* Mental health consumer
- *“...we spent a lot of years pretending there was something else wrong with [husband]. He knows what was wrong [depression] but he didn’t want anybody to know.”* Mental health carer
- *“If someone has a broken leg, they [employers] check on them all the time. They’re encouraging them to come back slowly into work. If you have a mental illness, they don’t say that.”* Mental health consumer
- *“Employers use that [mental illness] against you in your promotion.”* Mental health consumer
- *“I think employers are reluctant. It’s very hard if you have any sort of disability, let alone a mental illness that you’re open about, to then be able to get employment.”* Mental health consumer

Some consumers also internalise feelings of stigma and have feelings of shame. For example:

- *“There is a stigma amongst the mentally ill themselves; that they are guilty, that they are weak.”* Mental health carer
- *“You keep it to yourself because you’re ashamed of it.”* Mental health consumer

Stigma and discrimination is key issue not only in family and work life, but also within the insurance industry. *beyondblue* has been working with the mental health and life insurance sectors since 2001 to improve insurance outcomes for people with a history of mental illness. Since this time there have been key achievements, including the development of industry-wide guidelines for insurance sector staff, enhanced communication between sectors, clearer complaints-monitoring processes, and the development and dissemination of a consumer guide.

A recent survey of consumer experiences with insurance conducted by *beyondblue* and the Mental Health Council of Australia (MHCA) in 2010 demonstrates that Australians who experience mental illness face substantial difficulties when seeking all types of insurance products (e.g. life, income protection, travel, health) that are otherwise readily available to people without a history of mental illness.¹¹ Over 35 per cent of respondents strongly agreed that it was difficult for them to obtain any type of insurance due to them having experienced mental illness. This almost doubled, increasing to 67 per cent for life and income protection insurance. Survey respondents reported experiencing significant discrimination when applying for insurance products and making claims against their policies:

- *“My broker said that income protection insurance would be too hard to get because of my history so don’t bother applying and I was advised it would be declined and thus didn’t take it further...”* Survey respondent
- *“...I decided not to take up the product for the time being b/c I felt discriminated against and deeply affected by the stigma and shame the whole process (answering the questions etc) made me feel.”* Survey respondent
- *“...too many people were claiming for depression and they were not prepared to insure people with depression. They stated that people were claiming like they used to with back problems, that too many people could feign depression and make claims.”* Survey respondent
- *“I was very concerned about the way in which these [questions] were asked e.g. (verbatim) “Are you currently suicidal or do you have plans to commit suicide within the next twelve months? Have you had suicide attempts? We need to know all of this because it will impact on your policy and ability to make claims. I can add it as an inclusion that suicide may be a possibility, but you will likely have to pay more. Would you like me to include that suicide is a possibility?”* Survey respondent

The survey findings reinforce that a major factor contributing to stigma and discrimination across the insurance sector and work and family life, is the limited understanding of mental health problems, diagnoses and symptoms. In the future *beyondblue*, with the MHCA and Australian Human Rights Commission, will bring together key stakeholders and decision-makers from the mental health sector, insurance sector and consumer advocacy organisations to work collectively to increase awareness and understanding of mental health problems, reduce discrimination and stigma, and improve insurance outcomes for mental health consumers.

While *beyondblue* is continuing to undertake national and targeted campaigns and programs to decrease stigma and discrimination, it is essential that this is supported by the broader community. An ongoing, collaborative and multisectoral approach is needed to decrease the stigma and discrimination experienced by people with depression and anxiety and their carers.

Recommendations

28. Support the development and implementation of ongoing, collaborative and multisectoral initiatives to decrease the stigma and discrimination associated with depression and anxiety.
29. Improve insurance policies and practice to reduce the discrimination that consumers and carers experience when attempting to purchase or make a claim against insurance policies.

-
- ⁱ Australian Bureau of Statistics (2008). *2007 National Survey of Mental Health and Wellbeing: Summary of Results (4326.0)*. Canberra: ABS.
- ⁱⁱ Australian Bureau of Statistics (2008). *2007 National Survey of Mental Health and Wellbeing: Summary of Results (4326.0)*. Canberra: ABS.
- ⁱⁱⁱ Clarke, D.M. & Currie, K.C. (2009). 'Depression, anxiety and their relationship with chronic diseases: a review of the epidemiology, risk and treatment evidence'. *MJA Supplement*, 190, S54 - S60.
- ^{iv} Begg, S., et al. (2007). *The burden of disease and injury in Australia 2003*. Canberra: AIHW.
- ^v World Health Organization (2008). *Global Burden of Disease 2004*. Switzerland: World Health Organization
- ^{vi} LaMontagne, AD., Sanderson, K. & Cocker, F. (2010). *Estimating the economic benefits of eliminating job strain as a risk factor for depression: summary report*. Melbourne: Victorian Health Promotion Foundation (VicHealth).
- ^{vii} Cummins, R.A., et al. (2007). *Australian Unity Wellbeing Index, Survey 16.1, Special Report*, in *The Wellbeing of Australians - Carer Health and Wellbeing*. Victoria: Deakin University.
- ^{viii} Australian Government (2009). *National Mental Health and Disability Employment Strategy*. Accessed online 29 April 2011: http://www.workplace.gov.au/NR/rdonlyres/6AA4D8AD-B1A6-4EAD-9FD5-BFFFEBF77BBF/0/NHMDES_paper.pdf
- ^{ix} Pirkis, J., Harris, M., Hall, W. & Ftanou, M. (2011). *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative Summative Evaluation: Final Report*.
- ^x Pirkis, J & Harris, M. (2011). Were the budgetary reforms to the Better Access for Mental Health initiative appropriate? Yes. *eMJA Rapid Online Publication 12 May 2011*.
- ^{xi} Pirkis, J & Harris, M. (2011). Were the budgetary reforms to the Better Access for Mental Health initiative appropriate? Yes. *eMJA Rapid Online Publication 12 May 2011*.
- ^{xii} Australian National Audit Office. (2011). *Administration of the Access to Allied Psychological Services Program*. Accessed online 18 July 2011: <http://www.anao.gov.au/Publications/Audit-Reports/2010-2011/Administration-of-the-Access-to-Allied-Psychological-Services-Program>
- ^{xiii} Bassilios, B et al. (2011). *Evaluating the Access to Allied Psychological Services (ATAPS) component of the Better Outcomes in Mental Health Care (BOiMHC) program: Seventeenth Interim Evaluation Report*. Accessed online 18 July 2011: http://boimhc.org/pub/Main/ATAPSReports/17th_Interim_Evaluation_Report.pdf
- ^{xiv} Australian National Audit Office. (2011). *Administration of the Access to Allied Psychological Services Program*. Accessed online 18 July 2011: <http://www.anao.gov.au/Publications/Audit-Reports/2010-2011/Administration-of-the-Access-to-Allied-Psychological-Services-Program>
- ^{xv} Bassilios, B et al. (2011). *Evaluating the Access to Allied Psychological Services (ATAPS) component of the Better Outcomes in Mental Health Care (BOiMHC) program: Seventeenth Interim Evaluation Report*. Accessed online 18 July 2011: http://boimhc.org/pub/Main/ATAPSReports/17th_Interim_Evaluation_Report.pdf
- ^{xvi} Australian Government. (2011). *Health care and social assistance*. Accessed online 18 July 2011: <http://www.skillsinfo.gov.au/NR/rdonlyres/66356538-473E-4A8D-B795-F55F9F057D85/0/HealthCareandSocialAssistanceReport2011.pdf>
- ^{xvii} Juriansz, D. (2010). *Mental Health in Drought affected Communities Initiative (MHDI): Independent Evaluation Report 2010. beyondblue*: Melbourne.
- ^{xviii} Standing Committee on Aboriginal and Torres Strait Islander Health, (2002) *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework*, AHMAC: Canberra.
- ^{xix} VicHealth (2008). *Ethnic and race-based discrimination as a determinant of mental health and wellbeing*. Research Summary 3. VicHealth: Melbourne
- ^{xx} Australian Institute of Health and Welfare (2008). *Australia's health 2008*. AIHW: Canberra
- ^{xxi} Forum of Australian Services for Survivors of Torture and Trauma. (2011). *From the darkness to the light: Australia's Program of Assistance for Survivors of Torture and Trauma*. FASST: Melbourne
- ^{xxii} Australian Institute of Health and Welfare (2008). *Australia's health 2008*. AIHW: Canberra
- ^{xxiii} Department of Immigration and Citizenship (2011). *Translating and Interpreting Service*. Accessed online 25 July 2011: http://www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/
- ^{xxiv} Muir, K., Craig, L., Sawrikar, P. (2011). *Focus group research for beyondblue with consumers and carers*. University of New South Wales
-

-
- ^{xxv} Australian Institute of Health and Welfare (2011). *The health and wellbeing of Australia's Aboriginal and Torres Strait Islander people: an overview*. AIHW: Canberra.
- ^{xxvi} Australian Institute of Health and Welfare (2011). *The health and wellbeing of Australia's Aboriginal and Torres Strait Islander people: an overview*. AIHW: Canberra.
- ^{xxvii} Purdie, N., Dugeon, P & Walker R. (eds.). (2010). *Working together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. Department of Health and Ageing: Canberra.
- ^{xxviii} Purdie, N., Dugeon, P & Walker R. (eds.). (2010). *Working together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. Department of Health and Ageing: Canberra.
- ^{xxix} Purdie, N., Dugeon, P & Walker R. (eds.). (2010). *Working together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. Department of Health and Ageing: Canberra.
- ^{xxx} Purdie, N., Dugeon, P & Walker R. (eds.). (2010). *Working together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. Department of Health and Ageing: Canberra.
- ^{xxxi} Purdie, N., Dugeon, P & Walker R. (eds.). (2010). *Working together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. Department of Health and Ageing: Canberra.
- ^{xxxii} Purdie, N., Dugeon, P & Walker R. (eds.). (2010). *Working together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. Department of Health and Ageing: Canberra.
- ^{xxxiii} Purdie, N., Dugeon, P & Walker R. (eds.). (2010). *Working together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. Department of Health and Ageing: Canberra.
- ^{xxxiv} Australian Bureau of Statistics. (2008). *Aspects of Disability and Health in Australia, 2007-2008*. ABS: Canberra
- ^{xxxv} Australian Bureau of Statistics. (2008). *Aspects of Disability and Health in Australia, 2007-2008*. ABS: Canberra
- ^{xxxvi} Andrews, G., Henderson, S & Hall, W. (2001). Prevalence, comorbidity, disability and service utilisation: Overview of the Australian National Mental Health Survey. *The British Journal of Psychiatry*, 178, 145 – 153.
- ^{xxxvii} Andrews, G., Henderson, S & Hall, W. (2001). Prevalence, comorbidity, disability and service utilisation: Overview of the Australian National Mental Health Survey. *The British Journal of Psychiatry*, 178, 145 – 153.
- ^{xxxviii} Griffiths, K.M., Farrer, L. & Christensen, H. (2010). The efficacy of internet interventions for depression and anxiety disorders: a review of randomised controlled trials. *Medical Journal of Australia*, 192 (11), S4 – S11.
- ^{xxxix} Christensen, H et al. (2010). *E-mental health: A 2020 vision and strategy for Australia*. Accessed online 29 July 2011:
http://www.ehub.anu.edu.au/pdf/Emental_Health_2020_Vision_and_Strategy_for_Australia.pdf
- ^{xl} Corboz, J., Dowsett, G., Mitchell, A, Couch, M., Agus, P., Pitts, M. (2008). *Feeling Queer and Blue: A review of the literature on depression, and related issues among gay, lesbian, bisexual and other homosexually active people*. Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne.
- ^{xli} Hillier, L., Jones, T., Monagle, M., Overton, N., Gahan, L., Blackman, J., and Mitchell, A. (2010). *Writing themselves in 3*. Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne
- ^{xlii} McNair, R., Hughes, T., and Szalacha, L. (2011). *Mental health and violence amongst young Australian women of diverse sexual orientation*. PowerPoint presentation prepared for *beyondblue* GLBTI Reference Group, January 2011.
- ^{xliii} Corboz, J., Dowsett, G., Mitchell, A, Couch, M., Agus, P., Pitts, M. (2008). *Feeling Queer and Blue: A review of the literature on depression, and related issues among gay, lesbian, bisexual and other homosexually active people*. Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne.

-
- ^{xliv} Corboz, J., Dowsett, G., Mitchell, A, Couch, M., Agus, P., Pitts, M. (2008). *Feeling Queer and Blue: A review of the literature on depression, and related issues among gay, lesbian, bisexual and other homosexually active people*. Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne.
- ^{xlv} Corboz, J., Dowsett, G., Mitchell, A, Couch, M., Agus, P., Pitts, M. (2008). *Feeling Queer and Blue: A review of the literature on depression, and related issues among gay, lesbian, bisexual and other homosexually active people*. Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne.
- ^{xlvi} Pitts, M., Smith, A., and Mitchell, A. (2006). *Private Lives: a report on the health and wellbeing of GLBTI Australians*. Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne.
- ^{xlvii} Hillier, L., Jones, T., Monagle, M., Overton, N., Gahan, L., Blackman, J., and Mitchell, A. (2010). *Writing themselves in 3*. Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne
- ^{xlviii} Hillier, L., Jones, T., Monagle, M., Overton, N., Gahan, L., Blackman, J., and Mitchell, A. (2010). *Writing themselves in 3*. Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne
- ^{xlix} Pitts, M., Smith, A., and Mitchell, A. (2006). *Private Lives: a report on the health and wellbeing of GLBTI Australians*. Australian Research Centre in Sex, Health and Society, La Trobe University: Melbourne.
- ⁱ *beyondblue: the national depression initiative* (2010). *beyondblue* Depression Monitor. Available on request.
- ⁱⁱ Mental Health Council of Australia & *beyondblue: the national depression initiative*. (2011). *Mental health, discrimination and insurance: A survey of consumer experiences 2011*. Accessed online 29 July 2011: http://www.beyondblue.org.au/index.aspx?link_id=4.62&tmp=FileDownload&fid=2116