

**SUB.0002.0032.0075**

Submission for the Royal Commission into mental Health 2019

I'm an allied health professional who has worked in community health for most of my career. I developed an interest in mental health, particularly the impact of disruptions in early attachment relationships, and developmental trauma through my own experience of being a child of a parent with a mental illness. I have worked extremely hard in personal therapy over many years to manage the impact of what I have come to understand now as complex trauma. In 2018 I made the transition from working in community health to working in a CAMHS setting. I thought I'd realised a long awaited dream to be able to offer children who were scared, anxious, lonely and confused the kind of support and skills that I had missed as a child. I am sorry to say that I lasted in the role for 9 months. By no means do I wish to diminish the skills and commitment of the workers there or the incredible work they do, however the fantasy I had of working in CAMHS was far from the reality. I think I had anticipated that I would be entering some kind of therapeutic bubble, where there would be a culture of self care and compassion, where management would value and actively support sustainable work practices. What I found in the main were overburdened staff who worked through their lunch breaks, stayed back late, who sat isolated in their offices at their computers, barely raising their heads at times to say good morning. The lack of self care was astonishing to me given I'd spent years in therapy learning to listen to my body's signals, notice when I'm feeling stressed, and attend as best I could to my own needs so that I could be present and open enough to connect with my clients. It didn't make sense that these people were working in a system whose core business is to support client's mental health, but were clearly on the road to burnout and breaking point themselves. Ironically - and tragically - it was as if the system that was designed to support the 'unwell', was sick itself. My experience, and I think it is echoed across the sector, is that there is just not enough funding going to the places that need it. Referrals are increasing, clients are requiring complex case management, but teams are often understaffed for months at a time. Having to sit through team meetings witnessing workers desperately trying to juggle their already full caseloads being told that their 'targets' were down, waiting lists were growing, but there was no more funding for extra staffing was demoralizing. It appeared that the expectation by management was to "deliver excellence in client outcomes" but without the resources to do so in an effective way.

The answer to shorter waiting lists and more immediate access to mental health services doesn't lie in squeezing more out of the already overburdened staff, expecting them to become more 'innovative' in the way they deliver service. It doesn't lie in entering numbers into a computer to justify how they spent their time that day, under constant threat that if the numbers don't add up they'll lose their funding. It's impossible for staff to meet the needs of their distressed and dysregulated clients when they are distressed and dysregulated themselves. This is a pressure cooker environment that is completely unsustainable. It's no wonder that staff become disheartened and apathetic.

**SUB.0002.0032.0075**

I think in order to attract, retain and better support the mental health workforce, it requires a recognition that good mental health care requires time and resources. The road to good mental health isn't easy. It isn't linear and it isn't simple. It's multifaceted and often recurrent. It's happens in relationship, through connection. And it takes time. And yes time is money.

Increase funding into the sector

Advocate for more realistic work loads.

Acknowledge and cater for those who will need long term intervention

Increase wages to reflect the complexity of the work that mental health staff engage in on a daily basis.

Improve conditions such as more flexible work hours, and access to more weeks annual leave.

Improved physical work environments that include less crowded offices and access to outdoor spaces.

Advocate for a cultural change so that workers self care is valued and paid more than lip service.

**SUB.0002.0032.0075**

During my time working in CAMHS there seemed to be a trend of distressed 14 year girls self harming, school refusing, socially isolated, often suicidal, attended by their equally distressed parents seeking help. These girls had gotten through primary school under the radar . Most had a history of some social difficulties but never accessed appropriate support and as they entered high school, the increased social demands outweighed their social capacities, triggering significant distress - the kind of distress that ends in ED after a suicide attempt, and a subsequent referral to CAMHS.

As a speech pathologist I could give them at best 3-4 sessions to assess their communication skills and would invariably recommend a referral for an ASD assessment. They then sat on a waiting list for an ASD assessment which could be anywhere up to 12 months -unless they were ageing out of the service (which cut off at 15) and we would try to refer them into the community. If the parents could afford a private ASD assessment, then that was the best outcome, though being a public service, most families couldn't. There were often tears, tears of frustration, desperation, a sense of hopelessness. Parents desperately wanting help for their child but no way to access it.

Speech Pathology in CAMHS is thin on the ground and EFT has to be fought for. 2/3 of the clients referred with mental health have a speech and language disorder, and most of them have never had a speech pathology assessment, much less access to appropriate therapy.

If these children were identified earlier and accessed appropriate and effective therapy, they may have avoided the almost inevitable trajectory into CAMHS.

If teachers were more confidently able to identify children at risk, if they had hope that identifying these kids would result in more than just a name on a perpetual waiting list, then maybe the outcome for these children would be different.

Access to affordable and timely specialist therapeutic assessment and intervention is crucial for these children and their families. But to be effective, the intervention needs to be at the adequate 'dosage'. In public schools children with only the most severe speech and language delays come with funding to access speech pathology intervention. That rules out the children with mild to moderate delays or those who have subtle but significant social communication difficulties as is frequently the case with girl's on the autism spectrum. These kids only option is for their parents to access private therapy at on average \$180 an hour. The current medicare rebate is around \$57. And you only get 5 sessions per calendar year . 5 sessions is nowhere near adequate dosage. To make real change most of these children will need regular ongoing therapy for a number of years.

To make a difference, kids with developmental difficulties or those at risk of social emotional difficulties need to be identified early, referred quickly, and

**SUB.0002.0032.0075**

seen frequently. They need a multi faceted and integrated approach that often involves a team of health professionals over an extended period of time.

Increase funding for early intervention particularly for children with developmental delays who often develop co-morbid mental health issues.

Increase the Medicare rebate for mental and allied health services, and remove the 5 session cap per calendar year.

Make funding support more available for children on the less severe end of the spectrum who don't currently qualify for NDIS

The language we use is important. Replace the word "disability" with something more inclusive and less divisive.