2019 Submission - Royal Commission into Victoria's Mental Health System

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Name
Anonymous

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"To begin, I am a registered psychologist working as a case manager in a community mental health team in the public sector. I provide mental health care to adults (aged 18-64) living with severe mental illnesses such as schizophrenia, psychotic depression, bipolar affective disorder, borderline personality disorder, among other complex issues. Having practiced in both the public and private sectors and interacted with peers working in the field, I have witnessed challenges experienced by both consumers and clinicians of mental health services in both sectors. I am passionate about helping to improve the system and feel a strong sense of urgency about this. I implore the Royal Commission to consider my feedback regarding the system below. More needs to be done to PROMOTE mental wellbeing and PREVENT mental illness, rather than just to treat mental illness. This is particularly relevant to intervening early with children and young people so that problems are less likely to continue into adulthood. Once in adulthood however, adults then need to develop a self-awareness of their internal struggles - and know how to identify possible mental health difficulties in others - so as to ensure help is sought early before problems further escalate. All of this starts with awareness and understanding of mental illness/health and the reduction of stigma and discrimination. FOR CHILDREN & ADOLESCENTS: Awareness and understanding of mental health should start from a young age and be implemented into the curriculum, from early childhood education, through to primary and secondary education. Children and adolescents should learn to be aware of and understand their internal world (e.g. emotions, physical sensations, thoughts, behaviours); skills and strategies on how to cope with difficulties (e.g. social and interpersonal skills, mindfulness the Mindfulness Curriculum by the organisation 'The Smiling Mind' is a great example); and avenues to seek support (e.g. parents, trusted adults, teachers, school counsellors, Kid's Helpline). This ensures that understanding of mental health will improve and stigma will reduce in generations to come. Of relevance, teachers should also be trained in basic mental health awareness and support, enabling them to feel well-resourced to identify students who are struggling, and for students to feel teachers are approachable. FOR ADULTS: More awareness needs to be spread about mental illness as well as suicide (the two can be related but do not always co-occur). A little-known fact is that the death toll for suicide is higher than the death toll on our roads; yet the advertising and awareness for road safety is infinitely more prevalent than that for suicide. Mental health and suicide are taboo subjects that should not be taboo. People die because they feel they cannot share how they truly feeling. A lot of work needs to be done to destigmatise these issues. This may be done through the media (social media, mass media campaigns). Much work has been done to spread awareness about depression and anxiety disorders (e.g. via BeyondBlue), and this should continue given their high prevalence. However, low-prevalence conditions with arguably more stigma attached (e.g. schizophrenia, psychotic disorders) should also receive some attention with important myths/misunderstandings dispelled (e.g. schizophrenia is not 'multiple personality disorder', not all people with schizophrenia are dangerous). Exposure to such media may then instigate

conversations. Even if conversations are contentious and difficult, they are important nonetheless."

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
See response to Q1 above and Q4 below.

What is already working well and what can be done better to prevent suicide?
"Suicide needs to be destigmatised in order for people to feel safe to talk about it. The myth that talking about suicide will might put it in someone's head needs to be broken. (See suggestions above regarding reducing stigma). The existing 24-hour crisis counselling and suicide support services (e.g. Lifeline, Suicide Call-Back Service etc.), as well as psychiatric triage lines connected to government health services, are crucial for the community and should continue to be funded. Both volunteers and professional triage clinicians who work around-the-clock in these services should be better recognised and compensated. People working in relevant fields (e.g. healthcare workers, paramedics, child and family services, legal services, police, teachers) should receive suicide awareness & prevention training (e.g. safeTALK). "

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.
"1. Public mental health services are not investing enough into PSYCHOLOGICAL assessment and intervention - when it is mental health that we are treating! This applies to public services for the adult population in particular (although some services are exceptional). The 'bio-psycho-social' model of mental health is well-known, yet the approach to therapeutic intervention in the public sector tends to focus on ""biological"" approaches (e.g. medication, physical health) and ""social"" approaches (e.g. advocacy, referral to other services, involving family members in treatment etc.). ""Psychological"" approaches are significantly neglected. Specifically, psychological assessment would help consumers, families, and other clinicians gain more comprehensive insight and understanding into a person's psychological problems (e.g. Where did the problems come from? What thoughts/emotions/behaviours are keeping the problems going?). Psychological therapy would then help people develop the INTERNAL knowledge, skills and strategies to cope with their mental health problems, instead of relying solely on EXTERNAL interventions alone (e.g. medication, hospital admissions, social supports). Although the role of biological and social interventions are undoubtedly crucial, psychological work helps people to help themselves! If individuals are better equipped to help themselves, this helps to relieve some of the immense pressure that healthcare and community support services are already under. A stronger focus on psychological assessment and intervention and allowing psychologists to focus on their discipline-specific skills is crucial to maximising wellbeing in the consumers of public mental health services (see also Q7 regarding workforce issues below. 2. There are too few inpatient psychiatric units and beds. Despite clinicians' best intentions, this often leads to people being turned away from emergency departments, and inpatients being discharged due to bed pressure demands before they are fully recovered. This means that vulnerable people are discharged into the community when they may put their own safety/wellbeing and that of others at risk, even if no ""imminent"" risk is evident. Possible risks include mental state deterioration / acute relapse (e.g. of psychotic illness, bipolar illness), suicide, self-harm, harm to others (e.g. due to not being in control of one's perception/emotion/behaviour), of homelessness (e.g. due to not having stable accommodation to

return to, etc). Furthermore, this places significant pressure on community teams and clinicians (whether public or private) to manage risks that are difficult to contain outside of an inpatient setting. More psychiatric units and beds are needed. 3. For many people, their first port-of-call for mental health issues is their primary healthcare provider: their General Practitioner (GP). Therefore, it is absolutely crucial for GPs to receive mandatory and more comprehensive training for mental health difficulties, and for them to better understand the multitude of referral pathways for the various issues that patients may approach them with. It might help for all GPs to have a quick-reference list of services related to mental health that they can access easily and promptly. (See also response to Q5 below)."

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

"Poor mental health is a multi-factorial issue. Factors driving poor mental health may include childhood trauma (e.g. abuse and neglect), socioeconomic disadvantage (e.g. unemployment, poor education and training, unstable accommodation/homelessness), physical health problems (e.g. physical illness, poor diet, lack of exercise, poor sleep), substance abuse, interpersonal conflict, lack of social and professional supports. These are complex societal issues that cannot be easily fixed but attempts do need to be made. Financial disadvantage stops people from being able to access services for mental health (e.g psychological assessment and therapy, private hospital admissions, private psychiatrists). Therefore, there needs to be more Medicare-rebated sessions for psychological / psychiatric services for the most vulnerable and disadvantaged. Currently only 10 sessions per calendar year are funded as part of the Better Access to Mental Health Care Plan which contradicts the existing evidence about the number of sessions needed for therapy to be useful. "

What are the needs of family members and carers and what can be done better to support them?

N/A

What can be done to attract, retain and better support the mental health workforce, including peer support workers?

"1. The clinician-to-patient ratio in community teams (e.g. case management) is too high to enable good quality and effective care. Depending on the organisation and team, one case manager may be looking after up to 20-50+ patients, while psychiatry registrars and consultant psychiatrists may have 60-90+ patients at any one time! Take a moment to consider the volume of work that potentially needs to be done for EACH consumer: Mental state monitoring, medication management, assessment and therapy, crisis and risk management, psychoeducation, communicating with families and carers, liaison with health professionals/support workers/other stakeholders, writing referrals to other services (e.g. NDIS, alcohol & drugs, gambling, financial, accommodation), professional reports and letters, advocacy the list is endless. (Note that this list does not even cover organisational requirements such as paperwork, or the professional development and training that health professionals are expected to undertake to maintain their AHPRA registration.) Therefore, the clinician-to-patient ratios are simply unsustainable to provide effective care, leaving clinicians burnt-out and disillusioned, with patients negatively impacted as a result. Reduced clinician-to-patient ratios should also be better enforced instead of constantly being stretched to meet demand. More funding for both human resources (i.e. more clinicians) AND additional office/clinic space and equipment to accommodate more workers would help

greatly to address this issue. 2. Top-down demands coming from the government and managerial levels of public health organisations are often disconnected from / out-of-touch with the reality of clinical work on the frontline. A key area where this is sorely felt: Paperwork demands (and other administrative tasks) are impeding upon quality care. Although clear documentation (e.g. progress notes, reports) is crucial, clinicians in the public sector spend far too much time in front of a computer filling out endless forms, paperwork and reports that do not in the end directly benefit the service consumer in any tangible way. The paperwork is cumbersome, time-consuming, and frustrating, particular when multiple documents/forms have overlapping purposes and repeated information. The time spent doing paperwork would be much better spent working directly with consumers and families, or doing tasks that directly serve THEM. The paperwork and administrative demands urgently need to be reviewed and streamlined to be made more efficient to make the work more meaningful for both clinicians and consumers. Additionally, managerial levels of organisations should seek feedback from frontline workers about the operation of mental health services and how they can be improved. The feedback should be carefully considered, addressed, and reflected in organisational and operational changes. 3. Mental health clinicians from different disciplines - particularly allied health staff - often do not have enough opportunities to utilise their discipline-specific knowledge and skills. Psychologists, occupational therapists, social workers, nurses are often hired in generic ""mental health clinician"" roles that can be filled by any discipline background (particularly in community mental health teams). Even if organisations attempt to recruit for a particular discipline, the nature of the job remains a generic one. Both consumers and clinicians suffer as a result: 1) Consumers miss out on the opportunity to obtain discipline-specific assessment and intervention that would result in more holistic care for their overall wellbeing. 2) When clinicians are not able to utilise discipline-specific skills, they may feel disillusioned, underappreciated, undervalued. This will contribute to dissatisfaction and frustration at work, increase the risk of burnout, increase sick-leave and staff turnover rates. There are many examples of how clinicians can use their unique skills to benefit consumers. Psychologists can assess and formulate the thinking/emotions/behavioural processes underlying a person's mental health difficulties and teach the person skills and strategies to cope (e.g. managing difficult thoughts, emotional regulation, distress tolerance, interpersonal skills). Occupational therapists can help to assess a person's everyday functioning and help individuals develop the required skills to function better (e.g. self-care skills, cooking skills, sensory modulation). Social workers would be well-positioned to intervene at the family and social systems level (e.g. family therapy, liaising with carers, services, schools if children are involved). As a psychologist, I am particularly passionate about advocating for psychological assessment and intervention in the public mental health sector I have already addressed the specific value of psychologists in a separate point in Q4 above. IN THE PRIVATE SECTOR: Business-owners of private clinics, hospitals, and private practices are prioritising their profits over quality care. Therefore, like clinicians in the public sector, those the private sector are also being expected to do an excessive amount of work in an unreasonable amount of time sometimes being forced to do unpaid work in their own time which compromises on quality care. For example, private psychology practice owners may schedule in too many patients for psychologists to see in one day to maximise profits. As a result, there is often insufficient time for the psychologist to properly assess, understand and formulate the problem for each unique individual, and tailor the treatment / therapy to each person effectively within the work hours given. The work may consequently be rushed; OR psychologists who are particularly conscientious may take time out in their own personal lives - to do preparation, formulation, report-writing, letter-writing etc. - to ensure that their clients get the quality care they deserve. Unfortunately, clinicians' own wellbeing and quality of life suffer as a result. The focus on profits may also lead to interpersonal conflict and lack of support

between business owners and clinicians who are trying to provide good and ethical care (even when the business owners are often healthcare professionals themselves!). For example, as a result of an underlying attitude that the customer is always right, clinicians may be blamed for client dissatisfaction or challenging / unreasonable client behaviour, even when the clinician is not at fault and should not be blamed for the issue. Some measures should be implemented in the private sector, to: a) Ensure that the focus on profits do not interfere with clinicians' capacity to provide good quality mental health care (e.g. clinicians should be able to choose the number of clients they see per day within limits); and b) Ensure that clinicians are not exploited and are better supported by business owners. "

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?
N/A

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
"To summarise the suggestions already outlined above: - Reduced clinician-to-patient ratios in public community mental health teams - A stronger focus on psychology (psychological assessment and intervention) in public mental health services - Ensuring mental health clinicians in public services can utilise their discipline-specific skills - A review of paperwork/administrative demands in public mental health services, to make them more streamlined and efficient - More Medicare-rebated sessions for private psychological / psychiatric services - More inpatient psychiatric units and beds - Improved and mandatory mental health training for GPs - Measures to ensure private mental health services/business owners are not exploiting their clinicians and compromising on quality care for profits - Education on mental health and wellbeing in the school curriculum from a young age - More awareness being spread about mental health, suicide, lower-prevalence disorders (such as psychotic illness) In addition to this: The disconnect/loophole between the justice system and mental health system that enables people who are incarcerated to refuse treatment (when they are on a Treatment Order in the community) desperately needs to be addressed. There are consumers of public mental health services who are also involved in the justice system - specifically, they may be incarcerated for their crimes. As the system currently operates, the 'Mental Health Act 2014' enabling compulsory psychiatric treatment is only valid when individuals are living the community. Once a mental health service consumer is incarcerated or under the care of the justice system, the Mental Health Act no longer applies because they fall under Federal (rather than State) jurisdiction. This means that individuals who are staying mentally well due to being on a Community Treatment Order can opt-out of treatment once they are in jail. As a result of this loophole, vulnerable people are left to experience relapses of their illness (and subsequent brain damage) due to their own choices, in a harsh environment that is already traumatic enough. Some of these individuals may lose control of their perception, emotions, and behaviour due not receiving treatment (e.g. medication), and subsequently place themselves and other people at risk (e.g. via self-harm or aggression towards staff and other inmates). Both the person involved, and those around them, lose out due to this loophole, which I believe needs to be closed. In other words, the validity of the Mental Health Act should persist even when individuals enter the justice / prison system. "

What can be done now to prepare for changes to Victorias mental health system and

support improvements to last?
N/A

Is there anything else you would like to share with the Royal Commission?
"'- Many support workers recruited to provide private NDIS services to those with psychiatric disabilities are very poorly trained, or not trained at all. I have needed to report support workers who have poor professional boundaries and/or otherwise do not engage in a professional manner with their clients. Education and training for these workers is crucial to protect some of the most vulnerable people in our society living with a disability (psychiatric or otherwise). - Government and organisations should allow everyone to take some paid leave to take care of our mental health - e.g. to take mental health leave, and to book appointments to see a psychologist/counsellor/psychiatrist etc. In this day-and-age, it is ludicrous that taking ""sick leave"" to look after one's psychological wellbeing is frowned upon because it is seen as illegitimate even in the field of mental health itself! Feeling ""physically"" unwell should not be seen as more ""legitimate"" than feeling mentally or emotionally unwell. Ultimately, mental health is equally important to physical health, and needs to be treated as such by government, organisations, and society at large. Thank you. "