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

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N/A

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What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"People fear what they don't understand. There is a wealth of information available on the internet from credible authoritative sources at State and Commonwealth level. Our local hospital health service has a health promotion branch, which does great work with physical health issues and communinty education. Perhaps we can encourage more mental health promtion and education sessions through this avenue and through secondary schools and tertiary institutions.   It would be wonderful if some code of responsibility existed in the print and electronic media, television etc. about the manner in which they report the mental health status of offenders, when presenting news. It is a known fact that people with mental illness are more likely to be victims of crime than perpetrators. If an alleged perpetrator has a mental illness it is often reported as a key or highly salient factor in the description of the person. This colours community opinion and fuels ill-informed fears. Which is worse to you: a person with schizophrenia, who attacks someone, or a person who is completely sane and attacks someone? I can medicate the schizophrenic. What do I do about the sane aggressor?"

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?
"Substance use and abuse (alcohol, cannabis, amphetamines, etc.) is commonplace. We have drug education in schools and on television, but experimentation and the lure of the forbidden will never be eliminated from human behaviour. Our attitude to substance abusers needs to be pragmatic not legalistic or morally high toned. Treatment programs, diversion programs, safe injecting rooms, prevention, education and rehabilitation should take precedence over using the justice system to discourage the user or the addict. I do not advocate such leniency for the trafficker and I understand sometimes the individual may be user/abuser/addict and trafficker simultaneously. Our existing efforts are well directed. Perhaps we simply need to maintain the impetus, increase the resources, remember the philosophy, and resist those community members, who still believe we can legislate profound change in fundamental human behaviour and experience. Addiction is an illness. It can also trigger other mental disorders, lead to physical deterioration, crime, and alienation from family and community. We no longer seem afflicted by mental health practitioners, who refuse to provide services to dual diagnosis clients until they sober up or detox from their chosen poison. However, handling intoxicated (all substances) clients with or without other diagnosed mental disorders is very demanding, risky to staff and bystanders, takes time and a lot of people (safety in numbers) well trained and working as a team.   Our local Police will provide specific input of their own into the demands placed upon them by dual diagnosis individuals at risk of self-harm or aggression to others. Medical staff are not trained or employed to provide security. Perhaps we need carefully chosen and trained security staff in attendance at hospitals, which are equipped with secure, safe, isolated withdrawal rooms for disturbed and aggressive or at risk self harming clients to be detained and observed and if

necessary and if possible medicated during their detox before proper assessment and diagnosis can be undertaken."

What is already working well and what can be done better to prevent suicide?
"These days compared to ten years ago, there is a greater community awareness of the prevalence of suicidal ideation and therefore risk of suicide. Telephone services like Lifeline, Care Ring, Suicide HelpLine, Kids HelpLine, internet sites like Beyond Blue, Headspace etc. all these services are excellent in their own way. School wellbeing teams, community organisations, rural counsellors, GPs, Police members, these measures address the issue. Ultimately suicide is a phenomenon like domestic violence, bullying, and child abuse, which requires the whole community to be aware and to be prepared to do something, if and when it comes to their attention, even if all they do is ring a service for advice on what to do next. We have a tendency to use statistics as key performance indictors when evaluating our efforts to change and diminish harmful behaviour in society. They can be direct, clear and an excellent way of getting the message across in a 30 second sound bite or advertisement. However, we can over focus on these statistics and lose sight of the excellent work going on in the background. e.g. the Police are not failing us if the road toll increases, we have no way of capturing how many lives they have saved by road safety measures, especially in a State where there are more drivers and passengers on the roads every year. It is the same or similar with mental health services. We should continue to fund the existing services and help them sustain their efforts without linking the funding to statistics, which are at best a surrogate measure of performance or success. Perhaps the notion of caring for our neighbour, colleague, friend, team mate, whoever - through ongoing community education is an efficient way to address suicide risk across the State. "

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.
"Mental health and financial resources are inextricably linked it seems. We are working to improve our lives but as a society we seem to identify this strongly with purchasing power. Some people have very real financial needs going unaddressed - poverty brings ill health physically and mentally. Unemployment, homelessness, addiction, drought, floods, structural shifts in the economy. Other people are employed and struggling or have set themselves on a treadmill chasing success. Many years ago the 'Life Be In It"" campaign helped remind us to ""Live more"" of our lives. Community education is important in guiding people to live healthy lives. The cost of accessing mental health services privately is prohibitive for most people, who need them. Government funding at State and Commonwealth level is essential. Finding appropriately qualified service providers, who will bulk bill or set fees at a level patients/clients can afford is difficult especially in rural communities. The Medicare funding for mental health services must continue and for some chronic patients they need more than 10 sessions in a calendar year. If a client is acute on referral they might need sessions a week or a fortnight apart. That very quickly uses up ten sessions. The Medicare rate for ongoing services to patients with chronic conditions is lower per hour than for the newly referred patients. That would discourage providers from seeing the client for an ongoing period (perhaps that is the purpose behind the two tier hourly rate but chronic illness is no less difficult to tackle than acute illness in mental health). As a registered psychologist I have concerns over the comparative lack of men in my profession and what I see as a risk for instability in the psychologist workforce. I re-trained into psychology about 20 years ago. My perception is that the gender balance in my tertiary studies courses (all at Monash University -

Grad Dip, PostGrad DIp, Masters) was about 80% female 20% male. I suspect Social Work courses might not be too dissimilar. We want to encourage men to be more proactive in seeking help for mental health problems but I fear we might not have sufficient male counsellors available for those men, who for one reason of another find it difficult to talk to women counsellors. Some incentive or encouragement to attract men into Social Work and Psychology might be appropriate here. One aspect of the gender split we have noticed in my rural community is that the bright intelligent young women, who have both a career in psychology and a family, become financially dependent upon their husbands income while they are having and raising children. The husband's income is of primary importance for paying the mortgage and household expenses. This has inclined the family to follow the husband's career path in preference to the wife's and so to move away from our town when opportunities come up for the husband elsewhere. Psychology is a highly mobile profession now with AHPRA registration valid everywhere in Australia, and fractional appointments with flexible hours always available somewhere. It is an ideal profession for young women who want an interesting career and a family. I am not trying to discourage women from becoming psychologists, I just lament the loss of three such bright young women from our small town in the last 8 years as they have followed their hsband's employment prospects. It has not been possible to attract replacements. If we could find replacements for rural communities the mobility issue would not matter. We are a community two hours drive or more from our nearest regional centre. Sometimes we have to go there for services and for someone with a mental illness, diagnosed or not, without family or a competent support network privately, getting to the regional centre to access services is so problematic the patient/client often won't even bother going. It is not unknown for acute services, which are oversubscribed for clients clamouring to be seen, to close a referral on a patient, sight unseen, and notate the reason as 'failure to engage' making it the patient's fault they can't travel 200 kilomteres for an appointment. Mental health services rotate professional staff every few years e.g. psychiatrists. Patients don't like that change of service provider. If you are unwell you don't want to have to re-tell your story every two years to someone diffferent. You don't want to be forced to think about the past and what you hope you have left behind. If you have an incurable condition and have been some years since first diagnosis your file will be very thick, inches thick. The new psychiatrist won't want to read all that, they don't have the time. Besides which they will want the patient to narrate their story to get a perception of how the patient sees and understands their experience. If the changes happened less often it would reduce the unpleasantness for the patient. Some patients will avoid service providers because of changing personnel. When professionals talk to each other or communicate by email (GP, Psychologist, Social Worker, Psychiatrist, Teacher, Paediatrician, etc.) patient access to services and outcomes seem to be better."

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

"We struggle to attract qualified health professionals to our town. We are not metropolitan, we are not a regional centre. We dont have positions with high salaries for people rising in their profession or seeking a career path. We are too far from regional centres for young people or socially dynamic people to visit and return after their working day. We are limited in the profile of people, who would find living in our town and providing services to our community attractive. We have a lot to offer young families but as noted above they move on following the father's career path. Regional centre based professionals don't want to travel up here to provide service because the travel is onerous and eats into their days. Getting to them without suport is sometimes so difficult it seems impossible. Some community volunteers drive patients to the regional centre for physical health appointments. It may be possible to support an expansion of that service? Face to face

consultations are the best sevrice delivery format in my experience as a Medicare registered psychologist, and the father of someone with a chronic severe mental illness. I don't like electronic media sessions (Polycom, Skype etc). One loses the body language, the atmosphere is wrong, it is too clinical, rapport is harder to develop and maintain. It is a poor substitute for face to face in the consulting room. I have been trained and performed as a volunteer phone counsellor at Lifeline. I still dont like phone or Skype sessions unless they are unavoidable. Somehow we need to facilitate face to face sessions between service providers and clients/patients and try to find providers who might agree to come and live in our community for a fixed term appointment perhaps, say two years, and then rotate providers? "

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

"I am employed full time. Many carers are not because caring takes up their time. Carer support sessions take place during the day, so I usually don't go because it interferes with my work. I think it would be good for carers if they were able to do some work outside the home, to have a part of their life independent, to feel they engage in the world as themselves and not only as a carer. Carers can become co-dependent on their family member. They can become so wrapt up in their carer role that they cannot let go of it to take respite. Issues with their family member can become overblown, resonating abnormally large in the carer's life. As a psychologist in the school system I sometimes see this dynamic in single parent families, where a child or children have complex needs. Respite, carer groups, volunteering, part time employment, these opportuniteis may be present for some people but not others. I use some of my Commonwealth carer benefit (not sure if its an allowance or a carer payment - the one which is tax exempt and isnt a pension) , which is about $4,000 a year, to buy tickets to the MSO and Opera Australia. That's my respite. Drive to Melbourne in the season and go to a concert or an opera and then drive home (7 hours drive for a 3 hour show but it is me being free for a while). I am 65 years old; widowed. I wonder what will become of my son when i am dead. I wonder about supported accommodation later in his life, or if he can live at home, having a case worker who visits frequently. So I plan on living a long healthy life to take care of him and cross our bridges as they present themselves. "

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

"I don't have much experience of peer support workers. What little experience I have had involves only two or three such individuals. Much is made of the lived exerience of the disorder or illness, which the peer support worker draws upon to help the client, and which has often prompted the peer suport worker to help others. I would hope that there is some training and screening process to ensure the peer support worker has progressed beyond their experience, to a position in which they can provide thoughtful support and not assert personal bias or strong opinions about their experience of services. It is also important to recognise with mental health problems, at the time the person is experiencing them, their perception of reality is or may be distorted by the disorder. e.g. If I suffer from schizophrenia then, when I am well on the road to recovery, my recollections of my lived experience are filtered through the psychosis I suffered. I am not reporting the recollections of a normal mind about what happened to me, I would be using my normal mind to report my perceptions of what happened when I was in my episode. "

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?

"I suspect at the level of the individual the answer to these questions will depend upon the person's profile of symptoms and the legacy of the illness. e.g. my son suffers from schizophrenia. You can provide him opportunities to attend social functions, sporting activities, perhaps even a workplace, but his paranoia remains unaffected by the large amount of medication he takes and he wouldn't attend. I could imagine a similar lack of response from a patient / client with poorly controlled depression or anxiety. I suggest that a program for addressing these issues would need to be administered by an agency but tailored to specific individuals. It should also not be a condition of participation that the program assist patients to mix with the general community. Some of these patients mix with each other, are only happy to mix with each other and not the general community, where they feel vulnerable to bias and stigma. We had such a program in Kerang and it was replaced because the participants were not accessing the general community only each other. The outcome of the review was patients were worse off not better off. "

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?

"More qualified mental health providers psychiatrists, psychologists, social workers, psychiatric nurses, providing services either through the general health system or otherwise funded by government, not privately at some horrendous hourly rate. More access to residential rehabilitation for substance users and mentally ill clients as a circuit breaker when they are overwhelmed at home in the community. Some form of secure, comfortable, safe space, isolated from others, for aggressive, violent, disturbed, at risk, suicidal, self harming, complex patients whilst they detox and come down from their episode - based at hospitals with trained staff to monitor, medicate, and supervise wellbeing of the patient prior to transfer to mainsteam psychiatric services. "

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?

"Government might commission, if it has not already, someone like the LaTrobe School of Rural Health, or Monash Rural Health etc. to look at how best to attract mental health professionals to the country and keep them on a workable rotation, acknowledging they will move on and making it a characteristic of the role. I have thought that the Department of Education should set itself to become the preferred employer for graduate psychologists looking to work a supervised placement to obtain registration with AHPRA. However, events have overtaken that idea. I understand AHPRA is doing away with the 4+2 path to registration and all future psychologists will need to be Masters qualified. That means mainly their placements will be done through university and for not more than six months. We will lose the possibility of hiring provisional psychologists for a two year period. The State government might lobby AHPRA to keep the 4 + 2 pathway open, even if only to address the need for practitioners in rural communities. The requirement for a Masters qualification to obtain registration with AHPRA will reduce the number of psychologists further. Perhaps the profession needs to consider some sort of mental health associate or para-psychologist practitioner, however one words it, to facilitate addressing the needs for mental health workers?"

Is there anything else you would like to share with the Royal Commission?

"Patients seem to do best when they have a key professional in their life to whom they can relate and with whom they feel supported. That person can then faciliate access to other services and

support the patient to develop a care team. For this to happen the human factor is most important; rapport, understanding, continuity of care, open and honest communication between the professionals involved. That person usually can't be the GP, they don't have the time. It can't be the psychiatrist, there aren't enough of them.   It might be a psychologist, or a social worker, or a trained mental health para-professional however so styled. If it's through an agency the aspect of continuity of support worker needs to be emphasised. It's a human endeavour; it needs to be client centred and ongoing."