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

Organisation Name
N/A

Name
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What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"All schools should have at least one (and in higher risk areas more than one) funded social worker/ wellbeing person or mental health OT employed to facilitate normalising communication about mental health, delivering preventative mental health programs, early intervention, family support services etc All general practices should have government funding for a mental health nurse +/- social worker to assist in primary care provision of mental health services within communities.   Providers of life insurance, income protection etc should not be excessively discriminating against people for being proactive and seeking help for mental health conditions."

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?
Local Macedon Ranges Shire Council Live For Life Program and Mental Health First Aid training availability has been a positive that has come from this areas response to the high suicide rate. The Mental Health Nurse Incentive Program was very worthwhile but limited in availability and it has recently changed to be overseen by Primary Health Networks and i am not sure how this is being managed in different areas. I know a couple of other General Practice Clinics in our region had their own MH nurse. Unfortunately the clinic I work at was not part of this program. I would have very much appreciated having a MH nurse in our clinic. A new program this year called the Enrich Program though Cobaw Community Health has been invaluable in assisting patient care beyond what can be provided from within the consulting room as a GP. The MH nurse and secondary psychiatric consultation within this program has allowed much better coordinated and collaborative care that has really enabled a positive shift in my patients situations. This program has worked as the MH nurse has visited families at home and met with youth in areas within the home or genral community- outside of traditional clinical service facilities. (https://www.cobaw.org.au/services-a-z/young-people/enrich-youth-program/) Other new programs at local schools geared towards addressing school refusal are making a difference where previously I have felt at a loss as a GP to influence. Previous programs such as PHAMS (Personal Helpers and Mentors Service) run by St Lukes Anglicare in this area was a fabulous program as it allowed assistance to be provided within the patient's home and offered practical as well as emotional support within the community helping patients with self management and to better engage in their own needs and with community resources. Unfortunately the commencement of the NDIS has mean that this service is no longer available (though similar services are available if a patient has NDIS funding). A lot of mental health conditions will not meet criteria of being a permanent condition to qualify for NDIS funds - despite patients being significantly psychosocially impaired in the medium to long term. To no longer have such services available to assist recovery for these patients has been extremely frustrating from a providers perspective and tragic from the patient perspective.

What is already working well and what can be done better to prevent suicide?
"As described above local shire council MH First Aid training. Encouraging respectful community connections in all areas of life and between different organisations - schools, sports, the arts, police, emergency services, religious faiths, indigenous and peoples of other cultures. I wish I had some better answers here. I think key in better preventing suicide is to have better trauma informed care. The more severe and chronic mental health conditions I see usually have an aspect of severe past childhood trauma underlying it all. Increased medicare rebates for longer consults by GPs would also assist the area of suicide prevention. If a GP decides to spend longer in consulting with a patient at risk of suicide and bulkbills them then they will earn less per hour than a GP seeing 4 patients in 1 hr for standard less complex consults. In fact the medicare rebate for a prolonged consult of 40 mins or more is the maximum that can be billed even though a GP might consult the patient for 1 hr or longer in taking a comprehensive history and assessment of immediate risk, making phone calls, arranging referrals or follow up, commencing specific therapies, arranging admission, awaiting family/ support persons assistance etc. This is exactly where MH nurses or MH OTs and Social workers would be invaluable in the general practice setting. "

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.
"PAST CHILDHOOD TRAUMA- is the most significant issue impacting a large number of patients with chronic mental health conditions. Also attachment issues from early childhood is another great contributor to MH conditions- so parenting support/ community support services are so important here. Parental leave, social/ cultural change to allow both parents adequate time at home with children in the first 1000 days of life- even things like encouragement of job sharing arrangements eg- so both parents can work 3 days a week each and minimise external childcare. Programs of training professionals in training such as Newborn Behavioural Observations training- https://www.thewomens.org.au/health-professionals/clinical-education-training/nbo-australia/nbo-training. Parent / family support training programs- eg Triple P Need better access to family therapy services in rural and regional areas. Bouverie is in melbourne and difficult to access - though is an excellent service. All community health centres should have affordable family therapy services(which is usually not available to be billed under a mental health plan). To improve this area we need awareness of the ACE studies- Adverse Childhood Experiences and how past childhood trauma affects health and how to provide care in a trauma informed manner- with not just mental health but with physical health conditions. Other things that make it hard for people to experience good mental health are primary and secondary students having undetected/ undiagnosed learning difficulties such as dyslexia, dyscalculia, dysgraphia, ADHD, Autism Spectrum. Not having early diagnosis/ APPROPRIATE interventions with these conditions can have significant effects on one's self esteem and ongoing learning ability with longterm effects into adulthood. Many people within the criminal justice system have learning difficulties- many probably undiagnosed - had they been identified in primary school and attended to may have prevented a pathway into drug use/ crimes etc. There is a multitude of services but many overlap and there are also may gaps. Living in a semirural area on the border between 2 local area mental health regions has proven difficult fo some patients as they have moved between the 2 areas over the yrs and any case management has had to shift between teams- thus disrupting care. As a GP it is very difficult to have a patient accepted for case management within the local mental health team unless they are an extremely high suicide risk or psychotic. Some local mental health teams have different attitudes towards managing/ engaging with specific MH areas. Eg- My local mental health

area team has been resistant to engaging with Borderline Personality Disorder (BPD) patients- who are sometimes chronically suicidal. I am aware of mental health teams in other areas that have actually supported their staff in receiving specific evidence based training to better manage patients with BPD (eg Dialectical Behaviour Therapy Training) Such teams have then set up their own local DBT programs. There is one BPD specialist treatment program in Victoria called Spectrum- every local mental health team should have some staff that have had training at Spectrum and BPD specific treatment groups should be available in all regional areas- not just Melbourne CBD. I often encourage patients with chronic MH conditions to take out private cover just so they can access some of the excellent group outpatient day programs run by the private MH clinics in melbourne Unfortunately these patients usually cannot afford private health cover and cannot afford the out of pocket costs of seeing a psychiatrist which they need to in order to be able to access these private clinic programs. There needs to be more public local group therapy services outside of the city. I also think that local mental health teams should have positions made available for GP's as liaisons within the teams to better promote communication and clinical handover and possibly re referral to the public local mental health teams."

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
CHRONIC CHILDHOOD TRAUMA- ACE experiences. Culture of alcohol and drug use in some areas. Decreased availability of services in rural areas. We need more trauma informed care. Everywhere. Better dual diagnosis services. As a GP we too often hear that a patient has to have their drug and alcohol issue dealt with prior to MH team getting involved in their ongoing care. These issues are completely intertwined and you cannot treat one without attending to the other.

What are the needs of family members and carers and what can be done better to support them?
IN home visiting community teams to support better in the community.

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
"Better medicare rebates for long consults/ MH conditions. Employ MH nurses/ social workers, family therapists in every GP practice/ school etc"

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?
Every local mental health team needs to follow the guidelines regarding Bordelrine Personality Disorder management and have specific programs available within each team.
https://bpdfoundation.org.au/guideline-for-the-treatment-of-bpd.php

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
"Better awareness of the issue of past TRAUMA in CHILDHOOD of many mental health

conditions. Close the gaps that exist because of the different funding arrangements Federal versus State- Local council/ community health, primary health network, hospital, private and public, GP clinics etc"

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

I think the additional mental health plan funded sessions for eating disorder patients is an excellent idea- but this needs to be extended to all patients that have history of childhood trauma as 10 medicare rebateable visits with a psychologist are not adequate.