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

Organisation Name
M A Mathieson & Co Pty Ltd

Name
Mr Mark Mathieson

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"Currently mental illness is defined and operationalised within a dualistic / biomedical model. Whilst this simplifies the overall 'understanding' required, in many ways the simplification also acts as a barrier to understanding. In addition, the simplification of mental illness to labels and biomedical criteria facilitates a broad cross section of our communities to absolve themselves of any responsibilities to have potentially contributed. Schools, places of work, sporting and recreational clubs and many other components of our community need to understand that a large part of our 'culture' promotes lifestyle factors and approaches that our counter productive to mental health. Competition and consumer based cultural factors drive an ego-focussed culture that results in isolation, social competitiveness, a focus on the extrinsic goals and a lack of empathy. As a result individuals who struggle to 'keep pace' with the dominant cultural narrative feel shamed when considering seeking assistance, as it becomes a 'failure' to keep up with the proverbial ""Jones's"". Understanding of mental illness requires a broader educational (and challenge) agenda, that encourages deep reflection on what our culture has come to prioritise and hold up as desirable. A model of education that enables a cursory 'checklist' of solutions will do little to encourage radical change. Similarly, models of education that continue to enable the individual to carry the lions share of blame for falling ""ill"" with a mental ""ill""ness will continue to perpetuate a cultural narrative that prioritises competition and cultural isolation. Such being the case, increasing the Victorian communities understanding of mental illness requires a program of individual, group and community change that prioritises social connectiveness, relationships and community. Mental illness needs to be redefined as one possible outcome from a communities failure to support ALL of it's members, rather than an individual's failure to cope. Possible solutions include the inclusion of activities and projects within the secondary educational system, or other formal educational opportunities (TAFE, Universities, etc). Local governments could be encouraged to support and fund community development activities or programs that build positive communities and positive individual mental health. Funding levels for such programs would need to be sufficient enough to attract and retain tertiary qualified mental health professionals rather than untrained workers and individuals would require a broad and applied understanding of community change programs. Normalising the educational and responsibilities of being a member of a community would similarly go a long way to reducing stigma and discrimination around mental illness. "

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?
"The broad increase in community mental health literacy has gone a long way to encouraging early support and treatment. Individuals with a public profile that have commented publicly about their experience of mental illness (and in telling their story, normalised and reduced stigma) has similarly assisted. These processes of 'story telling' should continue to be encouraged, however a

more detailed story about the underlying drivers of mental illness needs to be encouraged. As our mental health literacy has grown, we now require a better ability to answer the 'but why' questions about the aetiology of mental health, rather than just have an understanding of 'what it is'. Prevention programs that encourage community based positive mental health (whilst embryonic and isolated) are similarly a positive step. Many are segmented and work from individually derived models. Few are standardised or driven or delivered by mental health professionals. Many run on a volunteer, para-professional basis with high-risk funding models. Schools, community and sporting groups should all be encouraged to provide educational and formal opportunities to build skills in awareness / understanding and early intervention. Formalising Rites of Passage programs into adulthood, and other stages of life should similarly be encouraged and standardised (assuming they are based on positive adult development models). Linking these preventative and developmental programs with the reactive biomedical and health model would be an important component of data sharing and early treatment and support."

What is already working well and what can be done better to prevent suicide?
"Awareness and education has similarly enhanced the communities knowledge about suicide and provided some basic (and largely appropriate) ways to provide 'mental health first aid'. Including formal mental health first aid training in educational institutions and work-places will continue to enhance the identification and early intervention with individuals at risk of suicide, much like current physiological first aid courses have become a 'normal' part of most community members secondary, tertiary or vocational education. Encouraging WorkCover to increase PsychoSocial Risk Assessment education and processes within Victorian workplaces is likely to rapidly drive change within our workplaces."

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.
"The dominant cultural narrative around consumption and competition drives a paradigm that disempowers members of our community to value and enact rest, recuperation, quietness, family and community time. Our communities are increasingly discouraged from connecting with nature, spending time relaxing with family and friends, turning off technology or consuming media. Community spaces are increasingly being designed to be 'entertained' rather than to be creative or imaginative or simply just to 'be'. A focus on revenue generation or risk-aversion appears to drive many local government plans to 'develop' their communities, rather than prioritising connection, calmness, relaxation and recharge. The same cultural values pervade the current paradigm of mental health treatment and access. Mental Health practitioners are often pressed for time, encouraged to use ever 'briefer' models of intervention and to obtain quick, short-acting tangible results (often in conjunction with pharmaceuticals that mask real change) rather than being funded to, or able to seek real solutions. Models of intervention are focussed on 'individuals' rather than being enable to see a patient as a member of a family / community. Services are poor connected and often operating from differing funding and philosophical models. There is a gigantic gap in service provision between community based mental health services and tertiary hospital in-patient care, with many individuals being trapped in a circular process between the two. A distinct lack of 'valuing the individual through a consistent relationship' results in individuals being bounced around multiple practitioners without feeling like anybody truly understands their situation."

What are the drivers behind some communities in Victoria experiencing poorer mental

health outcomes and what needs to be done to address this?
"Socioeconomic disadvantage drives a large component of communities experiencing poorer mental health outcomes. With many GP's and Psychologists (as well as other mental health providers) requiring a gap payment to remain profitable, the basic driver of access is access to funding. Publicly funded services are under-funded and overwhelmed and often only attract professionals who are seeking experience (newly qualified). The highly experienced segment of the mental health professions often work in private practice or consulting roles and have long waiting lists of those that can afford their 'better?' services. The lack of a requirement to measure outcomes in mental health 'treatment' enables less-skilled practitioners to remain in business. Many mental health professionals do not wish to move to rural and isolated areas as their relative affluence enables a more 'successful' lifestyle in an inner city urban environment or to increasingly specialise within the confines of an 'exciting' career only available in the city. At the same time, the lower socio-economic profile of many rural and isolated communities means they cannot afford to keep the experienced and skilled mental health professionals in the lifestyle they often can achieve in the city. Encouraging skilled and experienced professionals to move to and engage with lower socio-economic communities or isolated and rural communities is a key requirement in enhancing service provision within Victoria. Encouraging medicare to provide additional benefits to professionals working in communities in rural or isolated locations may be one methodology or other programs to financially or professionally recompense skilled mental health professionals."

What are the needs of family members and carers and what can be done better to support them?
Family members and carers are often excluded from accessing care or information about their loved ones as a result of a biomedical model that seeks to 'treat' individuals rather than the family / support unit as a whole. Encouraging models of care (and funding) that intervenes at a social / relational level rather than just and individual level is required.

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
"Dismantling some of the centralisation of power (and funding) that currently resides within the medical system would go a long way to enhance the image of the mental health workforce. Better funding models that are based on competence rather than arbitrary titles, labels or vocational positions would similarly encourage a workforce that is not protectionist. The current dualistic model of Medicare funding for Psychologists is a good example, where one group (Clinical Psychologists) receives a higher rebate for the same service provision and outcomes based on a title rather than competence. Changing the model of mental health service provision and funding to a preventative and resilience building model would also encourage an engaged workforce. As it stands, nearly all funding is reactive and based on 'treating' mental illness rather than preventing it or promoting good mental health. This results in many practitioners being disempower to act until an individual is already 'ill'."

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?
"Continuing to reduce the stigma around mental illness and providing education around modified participation in social and economic activities will go a long way to improving the participation rates of those with living with a mental illness. As mentioned above, normalising mental illness within

our culture and communities is required, and most likely best achieved through 'normal' educational processes (schooling, recreationally and vocationally). Encouraging schools and community groups to enact consistent and professional programs of cultural change and education towards positive mental health will be critical to achieving this."

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?
"Breaking down silos within the professional groups servicing the mental health industry as well as redesigning funding and access programs to facilitate better targeting of at-risk communities and individuals is crucial to the longer term strategic change. Challenging the dominant biomedical model of mental health care and considering alternative approaches to 'evidence based, scientifically proven' standards (that are often unachievable in the applied mental health field) will also enable and empower the mental health system to realign with a positive / preventative approach to mental health service provision."

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
"Empower members of our communities with lived experience to co-design a future mental health system that would suit them. Challenge sacred cows and silver spoons within the biomedical model and encourage a system that is broad and inclusive of social, relational, spiritual, psychological and ecological viewpoints and data, rather than just physiological."

Is there anything else you would like to share with the Royal Commission?
Consider and incorporate the views expressed by the UN Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health