Submission to the Royal Commission into Mental Health Services in Victoria 2019

My name is Dr Ben Samuel and I am a child psychiatrist. I work for the Child Psychiatry service at Monash Health and in private practice. I have been a fellow of the College of Psychiatrists for over 12 years and worked in mental health services in Victoria since 1999. I write this submission on behalf of myself and the views below do not necessarily represent those of Monash Health or other organisations that I am affiliated with.

May I start by thanking the commission for the invitation to contribute a submission to the Royal Commission. I valued the opportunity to attend the session on the 3rd of May 2019. It was notable that the position and ethic of the commission was to hear all views, no matter how difficult they may be. There was a willingness to take these views seriously and act where possible. Sadly, this ethic is too often missing in the interactions that mental health services have with those who seek their help. The actions of the Commission set a positive example for the cultural shift that I believe is required in Mental Health Services in Victoria.

Public mental health, especially in the area of child psychiatry, has experienced an extraordinary increase in demand over recent years. At the hospital I work at, Emergency departments have experienced approximately a 600% increase in mental health presentations for children over a 9 year period. Over the period of 2015-2017, our Child Psychiatry intake and assessment team have seen a 2-3 fold increase in new patient appointments. This increase is not solely due to population changes when there has been a population rise of only about 10% over the 5-year period from 2011-2016 in the 0-24 age group in this region. Interestingly, this has not been matched by a corresponding increase in adult presentations at this stage. Given the relative stability of psychiatric symptomology across the lifespan I predict that a considerable rise in adult presentations will follow over the coming decades.

The experience of mental health clinicians is that the nature of the work has not eased in terms of the degree of functional impairment in the children seen. The presentation of each individual child is no less challenging than it has been in the past. Many would argue that the "complexity" of presentations has increased over the past decade. Thus, I would argue that the increased rate of presentations is **not** merely representative of services now seeing the 'worried well' or an over-servicing of those who do not require help.

It is important to ask why we are experiencing such a monumental shift.

I would argue that there have been 3 main factors:

1) The medicalization of suffering. The past decade has seen a massive rise in so-called 'mental health promotion'. This has been with the noble aim of destigmatizing people with mental health problems and encouraging those who need help to access treatment. The "mental health literacy" campaigns run by Beyond Blue and others have focused largely on "depression" and "anxiety" giving the fundamental message that these constitute "illnesses" that have clear, effective and available treatments. These simplistic characterizations are hopelessly inadequate and narrow in

describing the nature of suffering and what should be done for those who emotionally suffer. They have shifted the prevailing culture to an idea that 'none shall suffer'. If one does suffer, there is a pill or treatment available. Whilst sometimes medications are unquestionably helpful or even necessary, the massive increases in rates of psychotropic drug prescription is frankly alarming. It has become increasingly common to see preschool children prescribed stimulants, antidepressants, antipsychotics and sedatives sometimes in combinations and for extended periods. Increasingly I hear "there must be something wrong with me/them". Paradoxically there can be an increase in stigmatization where people who are sad feel there is something wrong or faulty with them. This can become self-perpetuating leading to further shame, self-criticism and isolation. This becomes even more problematic when the medications or CBT 'don't work'. Often, the 'illness model' can lead to a lack of enquiry into the reasons or nature of a patients' suffering; in asking what it is that makes them sad or worried. Furthermore, the illness model has paralysed the community. Having worked with maternal child and health practitioners and more recently in the education sector, it is common to see emotional or behaviour issues in the people they work with and to hear them say "we're not trained in mental health", "we don't know what we're doing", "we don't want to open up a can of worms". A mysticism has developed around the emotional health of humans. Furthermore, we increasingly hear a demand for particular treatments to stop children being problematic: "we won't have him back at school unless he's medicated/or unless you can guarantee she won't hurt herself". Invariably, the questions of 'what's wrong?' or 'what's happened?' have not been asked. Frankly, I was horrified to read an article in a College of Psychiatrists Journal recently which strongly advocated for 'more mental health literacy' for young people.

2) The technological revolution. The first iPhone was released in 2007 and sold 1.39million units worldwide. In 2010, 40 million were sold and numbers have risen to stay above 200million/year since 2015. I believe it is no co-incidence that the rates of emotional and behavioural problems in children have risen world-wide during this period. Handheld electronic devices are clearly very popular for both adults and children (even before they can talk). They provide attractive images, immediate gratification and reduce the need for conversation. There is clear evidence that excessive use of electronic screens in young children is harmful. There are links with attentional problems, language delay, aggressive behaviours amongst others. The American College of Paediatrics and World Health Organization have both released guidelines for parents which recommend limits on screen time for young children with the first organization recommending no screen use for those under 2years and less than an hour per day for those less than 5 years. Sadly, these guidelines are little known and rarely followed. Governments have instead been working to *increase* access in primary and secondary schools. In teenagers, the rise of 'social media' and the internet broadly seems to have mixed effects. On the one hand it can increase social access and networks for those who might otherwise feel isolated or anxious. It can be useful in helping teens and adults access support and understanding in a quick and varied way. Unfortunately, it can also increase the sense of social exclusion, be a vehicle for cruelty and victimization and in some cases promote mental health problems (e.g. 'pro-anorexia sites', self-harming sites, release of images online which cause shame or other difficulties etc). Furthermore, there is the

impact on adults, especially parents. The Queen Elizabeth Centre in Nobel Park displays a poster with a message of "Your phone has replaced your alarm, your calendar, your CD collection, your camera and your notepad…..don't let it replace your family." Sadly, for many this has been the case. Australian adults spend 8 times as many hours per week looking at a screen than with loved ones. It's all too common in public areas to see parents and their children not interacting as both are mesmerised by their device. This is especially detrimental to young children who need interaction with responsive adults to promote their social and emotional development. The instant gratification that technology provides also has fundamentally reduced the capacity of people, particularly children, to tolerate emotions such as boredom, or to have time to think and reflect on their emotions and the emotions of others. It further adds to the narrative of "none shall suffer" and if you do suffer, there should be a quick and simple solution to that.

3) Changing family structures. The feminist movement following the Second World War was the beginning of one of the greatest changes in family structures in the history of mankind. There have been many effects of this change but I will focus on the entry of women into the workforce. I will start by overting that over 90% of the clinicians I've worked with over the past decade have been women. I enjoy working with women and believe they add skills and perspectives that are crucial to the workforce. Unfortunately, the entry of women into the workforce has not been matched sufficiently by men taking on parenting and childcare roles. During the first generation or so, this deficiency of available parents was supplemented in part by grandparents taking these roles. In short, parents spend less time supporting the social and emotional development of their children. The changes also raise the question of who's role is it to parent (amongst the other tasks of running a family)? This can create resentment, conflict, tension and uncertainty. Mothers feel guilty or resentful about not being able to adequately dedicate themselves to either their family or their job, and men can also feel challenged by changing workplace attitudes while also feeling inadequate in the home environment. Time dedicated to relationships are also overshadowed by the competing demands. These tensions, conflicts and dynamics are ultimately experienced and internalised by children. Exacerbating the problem are the above 2 changes where 'none shall suffer', leading to an intolerance of difficult emotions; and the easy use of devices to temporarily manage emotions. The sense of guilt of not being available to children can lead to a tendency to just make them happy, which in many cases denies their suffering or seeks to avoid it by reducing rules or limits. Parents increasingly give up on their roles and responsibilities as parents and delegate these to institutions or the 'TV nanny'. Children are left in tense, unhappy environments, which lack the authority of a present parent and are managed by the surrogate parent of technological devices.

Sadly, I see nothing to indicate that the rise in mental health presentations is likely to abate. Moreover, I fear that we face a tidal wave of presentations as the current primary aged children become teens and then adults.

How have mental health services responded?

As the number of people seeking help have increases to both child and adult services without a corresponding increase in resources, there has been an increasing rationing of what is offered. This is not only a resource issue. There is nothing so unpredictable as an encounter with another human, especially one who is suffering. The uniqueness of every presentation raises the question for clinicians and services about whether they can in fact offer something that will be useful to the patient. There is a desire in services to be offering something that will make the clinician feel good about what they offer. Hence there is a narrowing of what will be offered to certain areas of 'expertise'.

Rationing takes place often on the basis of so called 'risk'. There is a culture of only wanting patients with the right amount of 'risk' (often focused on the risk of suicide). Community and private services refer patients to public mental health when the patient is deemed "too risky" for their service. There is then a determination as to whether the patient has sufficient risks to be accepted into a service. Of course, if they are too risky, they are deflected to either emergency services or child protection. Services then spend an inordinate amount of time focusing on 'managing the risk'. This is done through the performing of repeated risk assessments, risk management plans and discussions at risk focused meetings. There are multiple problems with this approach. Firstly, there is little evidence that clinicians have any ability to predict the risk of a patient committing suicide. Furthermore, there is the questionable belief that working on risk management plans does anything to alter that risk. It may help to reduce the clinician's or institutions anxiety by having 'ticked all the boxes', but probably does little else for the vast majority of patients. There is a general failure to acknowledge that if a patient is determined to kill themselves there is little that mental health services can do about it. This is supported by the fact that the vast majority of people who suicide are never seen by public mental health services. Hence, those that are determined to suicide don't seek help. The focus on attempting to reduce the suicide rate has been nothing less than heroic with multiple suicide prevention strategies springing up at various levels. Despite these herculean efforts, suicide rates have changed little. Certainly, the advent and growth in use of psychotropic medications has not done anything to reduce suicide rates. What *has* changed is the language of patients who have recognised that the only way to get a service is to convince the right people of their risk of suicide. The result is a paralysing focus on 'the risk' rather than on helping patients work out what they might wish to do with their lives and how they can overcome the barriers that they face. In many cases my view would be that mental health services should be oriented *toward* boldness and taking risks. It is only through taking risks that people can engage in life in ways that counteract the deathliness of stuck repetition. Clinicians need to be bold in saying things that may be confronting to patients or to think 'outside the box' (especially when it is a suicide checklist!). Innovation and difference should be celebrated, rather than attempting to standardise and unify what we offer.

On a practical level, services have had different approaches to managing the increasing gap between increases in patient demand and limited resources. In taking an economic approach, there are 3 main ways of managing such a mismatch. An organisation can increase the cost of their services. Given the requirement for public mental health to be free, this is not an option. Secondly, there can be a reduction in access. We see this commonly in

the form of the development of 'gatekeeper' roles such as triage services, who are encouraged to reduce the numbers accessing services. This does have the advantage of maximising those being seen in the private system and other services, but creates inefficiencies when other services are also operating a 'gatekeeping' approach. The other manifestation of reducing access is the formation of waiting lists. Some patients on waiting lists end up using internal or external resources to address their difficulties. However, for others, the result is more entrenched problems or multiple contacts with services while on a waiting list that fail to address their difficulties. The third economic approach to resource deficiencies is to reduce the amount of what is offered. This takes the form of time limited interventions or pushing patients toward "discharge" prematurely. The effect here is for patients to either develop new symptoms or crises in order to remain connected with a service; or to bounce from service to service. This is incredibly inefficient as each service starts assessments anew and/or much time is spent in discussions between services to facilitate the transfer in either co-operative or hostile interactions. These dynamics can produce the frustrating emergence of 'the wasteland' which Honor Eastly vividly described in her emotive podcast 'No feeling is final'.

I believe there may be a fourth approach. This involves an assumption that patients do not want to see us indefinitely and will no longer use a service once they have managed to create change to the stuckness that causes suffering in their lives. In some cases, it involves a recognition that there is no 'fixing' their symptoms and the best step is to find a way to incorporate their symptom into a productive life. As mental health services it is incumbent on us to continually ask the question of ourselves as to how is this patient stuck, what prevents them from living a more fulfilling life and can we assist them in changing that? I would argue that this approach does more to reduce the risk of suicide than repeated assessments and crisis management plans. Services also need to be more willing to let patients leave our care in certain situations rather than taking a paternalistic position in insisting upon treatment. I have noticed an increased trend toward the acceptance of patients declining services, however this is not always appropriate (e.g. in severe psychotic states or life-threatening anorexia nervosa). It also needs to be supplemented by significant levels of support to the families and carers of the declining patients. This needs to go much further than a mere statement of "there's nothing we can do". As a general rule, mental health services have been sadly lacking in the assistance that has been provided to families. It is most striking when looking at RANZCP clinical guidelines for the treatment of schizophrenia. Only antipsychotic medications and family interventions have level 1 evidence for effectiveness, yet few adult mental health teams have sufficient staff with family therapy training. Families have been for too long been seen as needing to be managed to reduce complaints or needing to step up and support a patient better, rather than potential resources that can work in collaboration with services.

Working in Mental Health is at times a very difficult experience. Patients come to seek our help because they suffer an anguish or torment that they wish share. The sharing of such suffering is an intimate and painful process. People working in mental health are on the whole kind and driven by a desire to relieve others of their suffering. Clinicians can take the suffering with them until it takes a toll and a desire comes to produce barriers to the suffering.

What can we do to improve the system?

First and foremost, we need to create a culture of openness. One where people are welcomed to bring their suffering. This obviously needs to be true to mental health and related services where people are not turned away because they are too risky or not risky enough, too complex, have the wrong diagnosis etc. This may also extend to the idea of 'opening' and 'closing' 'episodes of care'. It is not entirely clear to me why patient files need to be closed and discharged. The only logical reason would be to discharge (or disavow) our responsibilities to them and make it more difficult for them to re-access care. The question of discharging patients is one that is endlessly discussed and often causes considerable stress to staff and patients without clear benefits to either.

Ideally the culture of openness should go beyond mental health services to include the broader systems that support people. Broader healthcare (e.g. maternal and child health, primary health and allied health), education and possibly beyond can all have a role in creating environments where people feel cared for and listened to. The construction of a narrative where 'emotional health is everybody's responsibility' would be a far more useful one than the current ideas that mental illness needs specialist treatment. This culture change would take time and commitment to change and runs the risk of health professionals and educators feeling underqualified for the task. The people working in these systems benefit from support in creating and maintaining this culture and this could be a role for mental health services. The CASEA (CAMHS in schools early action initiative) programs, Postnatal depression initiatives, and Primary Mental Health teams have already done some work in these areas and could be strengthened by more resources and a change in health promotion messaging. The first two initiatives also have added advantages in operating in the early intervention space of infancy and primary schools. As such they have the opportunity to alter the course of psychopathology in children from an early stage and hopefully reduce the need for resources across the lifespan.

We need to broaden the remit and capacity of existing services to learn how to better listen the people they help. Family support services (e.g. Child FIRST agencies) are often given the task of providing "case management". They can be invaluable in helping people in need navigate housing, welfare and other services. Their ability to sit and listen to the stories of their 'clients' is variable. The best clinicians do this exceptionally well. Others make multiple simultaneous referrals to multiple mental health and counselling agencies when their 'clients' would much rather talk openly with them or can feel overwhelmed by what they are told to do. Headspace services have received much publicity and funding for their programs. They undoubtedly do useful work with many patients. Unfortunately, the clinicians working within these centres will often refer on to public mental health services the patients that they consider either too complex or too risky. This can be distressing to the patient who has already taken a significant step in telling their story to a clinician only to be told that it is more severe than they can handle. It is also inefficient in having provided a service which the patient has not benefitted from as well as the liaison with the ongoing service. We need to better support existing services to hear the more difficult stories that their patients tell without shunting them off from service to service. We also need to better

resource the services who are unable to refer on their most risky/complex patients (i.e. public mental health) to work with patients more fully and for longer.

Pubic mental health services could be much more efficient than they are. The unnecessary time spent receiving and redirecting patients takes up the time of many clinicians who could otherwise be providing therapeutic services. Triage services and Emergency psychiatry clinicians are prime examples. This could be improved by better support/supervision of the above-mentioned agencies and changing attitudes with services so that the default answer is "yes, we'll see them" rather than finding reasons not to. There is also an enormous bureaucratic burden on clinicians in areas that provide no benefit to patients. These can be clinical such as time spent on registration forms, risk assessments, reporting contacts and outcome measures. Mandatory training in areas of little relevance to mental health (e.g. hand hygiene and manual handing of patients) also takes considerable time and resource as does dealing with rostering, leave and payroll issues. These burdens result in me personally seeing less than half the patients in public compared with private practice. Some of these are necessary and unavoidable, but hospitals would do well to think more carefully about how these burdens could be reduced rather than the current culture of adding on a training or protocol in response to any adverse incident. Furthermore, the risk adverse culture stifles creativity and the capacity to take clinically indicated risks that might be of benefit to patients.

Part of the inefficiencies come from the growth in the size of hospital networks and teams within them. The commission clearly had an understand about the most effective sizes for work groups being in numbers of somewhere between 5-10 (placing us in tables of that size). Work teams should be of a similar size. In smaller groups, decision making and communication becomes much more efficient and creative. Larger networks also lack the personal connections between teams for better liaison and co-operation. Co-location of teams that typically debate whether the patient belongs to one service or the other helps to reduce these debates and provide better outcomes to patients (e.g. co-location of drug and alcohol and mental health. Perhaps child protection and mental health co-location might be of value).

Residential and social services need to be better funded. Too often people are kept in hospital because they are homeless, in poverty or unsupported by the welfare system.

NDIS has created enormous services gaps. Recent news articles highlighted the difficult choice of families between trying to manage their disabled child with insufficient support or to give them up to the care of the state. Previous services for this group have been dismantled and new services are yet to take their place. The staff of the NDIS often have little understanding of the real needs of their clients and the creation of a 'for profit' system takes the focus away from what someone needs to what it costs. The added bureaucracy has also created inefficiencies for service providers.

Finally, we need to work with the college of psychiatrists and association of psychologists, along with those doing mental health promotion to re-language how we think about mental health. We need to move away from a medical illness model of mental health for the majority of patients toward one that values and normalizes emotional suffering. This will

involve a rethinking of how we train people to work in mental health that moves away from diagnosis, manualised therapy, medications to one that trains clinicians to effectively listen to the suffering of their patients and families.

Key recommendations:

1) Changing the language of mental health from one that is illness based and therefore only for specialists to one that creates a sense that mental health is everyone's responsibility and that all can have a role in improving the mental health of the community
2) Moving away from a culture of risk management to one that is prepared to take the risk of working with patients when the result is far from certain.
3) Changing the culture of "not me" where services constantly argue about who is the right service for a particular patient.
4) Resourcing family-based interventions
5) Resourcing residential services (inpatient beds, PARCS, Drug and alcohol rehab, homeless services for parents of young children, victims of family violence etc)
6) Creating smaller services which are more integrated e.g. small teams which co-locate Drug and alcohol, mental health and other services that typically debate the "not us, them".
7) Early intervention services that work with infants and young children in various ways (working with schools, expanding clinical services)
8) An education campaign focused on reducing the use of electronic screens for pre-school children and their parents.
9) Working with Colleges of psychiatry and psychology to improve training of clinicians in interventions not limited to CBT and medications. This includes supporting the funding of training and supervision in services.
10) Reducing the administrative and reporting load on services so clinicians can focus more on being clinicians.
11) NDIS – needs significant review.

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