MENTAL HEALTH ROYAL COMMISSION.

Submission from Dr A John Hodgson.

WHAT IS WORKING NOW?

The opinions and information from psychiatrists, both private and public is helpful. There has been a gradual improvement in their understanding of the social issues.

The information from Triage is becoming more helpful: I suspect I find it more helpful than others because of my past experience, and that I am better able to articulate what the problem is, what help I need, and that I am prepared to remain involved in the patient's care (do monitoring in the longer-term)

WHAT IS NOT WORKING?

Case Management by the Acute Sector: the case managers are overworked, so are reduced to ensuring medication is taken. They have little time for anything else.

Mental health is a long-term illness. It can't be treated with short-term interventions.

Assessment of risk remains important, but Issues of safety and vulnerability need to be give equal status. When patients are emotionally distraught and overwhelmed, the basics of shelter, food and clothing become paramount. Finances impact on acquiring these needs.

Accommodation needs to assist patients to feel safe and calm. This needs addressing not only from the type of accommodation, but also its local environment, especially if there are noisy and disruptive neighbors.

Vulnerability: the simplest solution, or first thought to solve an issue is often not the best! Patients with mental illness struggle to problem solve. They are very vulnerable to being manipulated.

Illicit drugs are forms of self-medication: they take away the burden: a holiday from the problems. We need to change our approach on illicit drugs away from zero tolerance, to one of harm minimization.

Intellectual capacity: goes to issues around problem solving.

WHAT USED TO WORK?

Mentally ill patients need both treatment, and **support. Support is often**:

Unavailable

Too long a wait

Short-term

Not frequent enough.

It needs to be flexible (Psych Disability Support Services, PDSS) worked very well. They should have been expanded, not abolished.

PMHT model: GP takes on "shared care" clients from Acute Services, and in return, psychiatrist consults ½ a day on a regular basis. Everyone learns alternative approaches to management.

MY THOUGHTS ON SOLUTIONS:

1. **The Acute Sector and the Primary Care Sectors have to co-operate better.** They need to develop **trust** around the safe and appropriate care of people with mental health problems. We need to look more closely at the interface between the sectors: **Acute Sector manages patients away from their living environment, while Primary Sector often has extensive knowledge of the needs, ability and quality and of the patient's living environment.** Discussion groups around planning for change seem to be the overseas models: we should look at these.

2. **Mental Health Literacy in Primary Care**: In order to facilitate this, GP's need to gain confidence in assisting people with mental health problems. As mental health problems usually involve **EMOTIONAL DISTRESS**, we need to learn how to better manage this. When should this begin: undergraduate, RACGP training, or post fellowship? I attach a paper I have written as a teaching aid for my RACGP registrars and practice staff. I am attaching as an example of the sort of approach I think we should take and am happy for it to be used in any way.

3. Psychiatry deals with the mental health that requires medication: I call this "mental illness": schizophrenia, bipolar, psychosis, major depression, etc. **General Practice mental health** is much more about emotional distress: **"Personality Disorders":** I prefer personality traits that tend to lead people into decisions based on emotional distress. Such decisions frequently result in poor outcomes (poor planning and poor judgement).

4. **GP's are good at monitoring patients**. We are also good at judging the quality of support available to a patient, because we know the family and local area. We can assist psychiatrists and mental health services in the monitoring of their patients if:
    a. We have a plan that summarizes the management , and highlights the "major signs of relapse"
    b. Allows us to contact the psychiatrist or service easily if we have a problem.

5. **Child and adolescent mental health**. The impact of the living and school environments on a child's mental health are well documented, as are the changes required. Would it be appropriate for GP's to write GP Mental Health Plans for parents to assist them in developing better parenting skills? In the past, play groups for young mothers with someone to assist with parenting advice were very useful.

6. **Personality Disorders** are best managed by the DBT model: the 5 steps problem solving technique. **There are only 2 sorts of problems in this world: ones you can solve, and ones you can't solve. Those you can't solve, you have to learn to live with.** I think this can be better taught to GP's (my attached PD document). I am not sure at which stage of a GP's training should this occur: undergraduate seems very busy, so perhaps RACGP registrar.

However, when I gave my PD document to GP's, nurses and receptionists, all found it very useful.

7. **Anxiety and Anger:** I feel these are very closely linked, as with both emotions, we all need space to enable us to calm ourselves down. Why when someone is distressed, is our first response often wanting to hug them? When we try to touch an anxious person, don't they often shrink back, and if we persist, they get angry? If we see angry people we often avoid them. If anxious children become angry, we leave them alone. We expect them to be able to calm themselves down. All of this requires us to "practice" emotional control in our day-to-day lives. Doesn't this require us to be interacting with actual people: on-line activities have no consequences, whereas real life does have consequences? Is this why sport and play are so important? In talking to young adults, I am often amazed at how many have insight, but seem to have grown up in un-insightful families. So many are very angry at the childhood they never got, but felt they should have. (However, parental anger or poor behavior has often been a contributing factor, so they don't want to be angry). They often present as anxious, or have turned to illicit drugs. They are both normal human responses to emotional distress: we have to learn to deal with them. Medication will not cure them!

8. **Communication between services and confidentiality**. This needs to be better defined. While the **treatment details** between doctor/service and patient need to remain confidential, the patient lives in a social environment. Within that environment, aspects of the individual's behavior are "common knowledge". Extended families and neighborhoods are often well aware of the patient's behaviors. GP's are often aware of the quality and availability of local supports; services are usually aware of what supports are needed to assist in patient management. Why can't the psychiatrist/service inform the GP of needs, and the GP arrange the service. This is particularly relevant to carers of patients who require tertiary mental health services and child and adolescent patients. The Headspace model seems to work well for

9. As GP's, if we monitor chronic psychiatric patient on behalf of the Acute Sector, and we better assess the emotionally distressed, and better advise them on appropriate treatment (psychologist rather than medication) this will save many dollars in the Health System. Can't I access some of that saving, and use it to employ staff such as mental health nurses to the benefit of everyone?

10. App's: we need a list of them

    a. ones for doctors to use as education tools when treating patients
    b. Ones to remind patient's when in crisis: consider videoing GP reminding them of salient points to help calm down, and reminders of what management was suggested.