

Submission re Draft Mental Health Report

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I am a consultant psychiatrist and specialist pain medicine physician. I applaud much of the draft report but wish to seek the Commissioners' consideration of the following:

In the 1980s we read an avalanche of literature pertaining to the psychiatric toxicity of unemployment. Despite that, one still sees a propensity for practitioners to encourage and support the taking of sick leave, especially when there is an alternative source of income by way of an insurance entitlement. This opens the patient to a set of unexpected, added toxicities, and sets in place a process of psychosocial deconditioning which, if allowed to go too long, compounds the total psychiatric adversity. *Mea culpa*, for over a couple decades I was one such practitioner, passionately defending my patients' rights to insurance entitlements, so blinded whilst "fighting the good fight" that I lost sight of another obligation of the medical practitioner: the professional and objective adjudication as to when the patient should be encouraged, despite reluctance or even fear, to gradually confront that through a graduated vocational rehabilitation.

Too many doctors, GP's and specialists too, are wedged in a pattern of "Abnormal Treatment Behaviour", as described by Melbourne psychiatrist Professor Bruce Singh in 1981. In the context of mental illness, and also of physical disorders (such as persistent yet potentially benign pain states) which are often associated with, or may lead to mental illness, too many doctors are supporting excessive and/or prolonged illness behaviour/sick-role adherence. This creates array of negative physical and psychobehavioural consequences which are detrimental to the patients' prognosis, and of course then also impact family, workplaces and those sectors responsible for health care provision and financial support of the sick person.

By way of analogy, the commissioners will recall the advice given in the "old days" for a sore back: bed rest for days even weeks; nowadays we appreciate the associated impact of deconditioning is too deleterious, and we get people up and about as quickly as is humanely reasonable. I believe, most firmly, that the same applies to people with psychiatric illnesses – and statistics confirm that the longer one is off work, the less likely it is that they will of return, and with that goes the hope of restoring a normal life for themselves and their families too.

In 2018, Sydney psychiatrist Dr M Modini published articles spotlighting the potential therapeutic benefits of broadening the scope of treatment planning via incorporation of sensitively designed and supported vocational reintegration protocols.

We need broader society, and doctors in particular, to appreciate that a vocational reintegration is just as important in treatment/mitigation of psychiatric morbidity as other behavioural strategies, such as regular exercise and social reintegration. The RACP has a monograph outlining the Health Benefits of Good Work (HBOGW). Many organisations – learned medical colleges, insurers and trade unions are signatories. I would respectfully submit that those learned colleges, especially the RACGP, RANZCP and RACP (Rehab) action their indicated support for this promoting their practitioners' awareness of the need to approach the return to work, a potentially therapeutic strategy, with the degree of appropriate consideration which is plainly warranted.

I submit that such a recommendation might be seen to fall reasonably within the remit of this enquiry.

Sincerely,

Newman Harris

Refs:

Singh, B. S., Nunn, K., Martin, J., & Yates, J. (1981). Abnormal treatment behaviour. *British Journal of Medical Psychology*, 54(1), 67–73.

Modini, M., Joyce, S., Mykletun, A., Christensen, H., Bryant, RA, Mitchell, PB (2016), The mental health benefits of employment: Results of a systematic meta-review. *Australasian Psychiatry* 24 (4), 331-336