

## SUBMISSION TO PRODUCTIVITY COMMISSION ON MENTAL HEALTH

### INTRODUCTION (AN UNDERSTANDING OF THE PROCESS OF MENTAL ILLNESS)

The brain is the major organ for all cognitive processes, behaviour and mood functions. Most people, and certainly all adults have experienced people with changes to their cognitive function, their behaviour and their mood in response to changes in their environment. The genes are said to be the bullets that are loaded into the guns, but it is lifestyle challenges that pull the triggers. A mental illness can be understood to be a condition of the brain that changes an individual's thinking, feelings, or behaviour (and sometimes all three). This then can cause that individual symptoms that are manifest as a distress and a difficulty in normal functioning. Scientists now believe as a result of investigations that the brains of people who have mental illnesses, show changes in the brain's structure, chemistry, and function and that mental illness does indeed have a neuro-physiological (biological) basis.

Now because the brain is involved in most of our daily processes and actions it is then being subjected to all the things that we experience during all of our waking hours. Therefore it is subjected to neuro-physiologic challenges for every minute of every hour of every day. Now that society has changed and mankind is challenged by information at an ever increasing rate via the media and social media, and new ways of receiving these messages are developing with rapidly changing technological changes, it can be easily realised that our brains are being bombarded with far more challenges than in the past per unit time. It is no wonder that it is estimated that one in four persons suffer a mental illness at any one time. This is not to say that others are not being significantly challenged at this time but at the time their symptoms did not deviate from the accepted range of normal. That is their coping mechanisms were allowing them to function normally.

What has not happened is that mankind's adaption to the increased challenges has not kept pace with these increased stresses. Our genes are what they are, with some people being more predisposed to mental illness than others, just as some people are more predisposed to bowel cancer or allergy to bees or penicillin. Governments and medical bodies have not been able to keep ahead of the environmental and lifestyle changes to protect individuals from these rapid brain challenges. There have been both primary, secondary and tertiary affects. An example of a primary affect is when an individual takes a substance that has a direct effect on the brain and alters its function. As a result of this effect the individual may not recover immediately, other disturbances of brain function occur (e.g. depression) or the individual may undertake a course of action which then compounds the individual's mental health and this is then a secondary affect. However as a result of these secondary affects another person, often a loved one can be affected as a tertiary manifestation and this is often seen in carers.

Thus at the outset it can be seen that there needs to be significant paradigm shifts in the thinking to alter the course of increasing mental illness in the community. As a country, as communities, as citizens, and as individuals we must absorb the need to change things as we do in facing equal opportunity, social biases, social behaviours as in driving vehicles, and

our attitude to our respect for our fellow man, our responsibility to life and our resilience (or ability to recover from setbacks). These changes need to be led from the top. The top of government. The top of organisations. The top of education. The top of our religions. And the top of the family structure (the parents).

#### THE WRITERS EXPERIENCE IN MENTAL HEALTH ISSUES

I am a qualified general practitioner who has now retired and is advocating in aged care, palliative care and mental health. I have for 28 years have had experience as a carer for a daughter who has a significant (severe) chronic mental health problem. I have officiated at mental health meetings for colleagues, and attended carer's meetings in a supportive role. I was the organiser of a mental health program on the ABC (Adelaide) with Peter Goers.

THIS SUBMISSION ADDRESSES THE HUMAN RIGHTS AND MENTAL HEALTH IN SOUTH AUSTRALIA AND THE QUESTIONS WHICH AROSE FROM THE PRODUCTIVITY COMMISSION ISSUES PAPER.

### PRODUCTIVITY COMMISSION ISSUES PAPER QUESTION ANSWERS

TOPIC 1: THE LACK OF HUMAN RIGHTS GENERALLY BUT ESPECIALLY WITH SEVERE, PERSISTENT, AND COMPLEX CASES OF MENTAL ILLNESS. The **assessment** emanates from discussion across most carers support groups (which form because they represent involved people who have a responsibility to a loved (cared for) person, and want to see improvement in a system where they see complexities and a standard that is not acceptable). This therefore represents a vast number of consumers where the carers recognise there is a deficiency in communication, understanding of the problems faced by the consumer, and a lack of expected progress. A consistent belief is that when a consumer needs to be readmitted, then the lack of dignity and certainty of being heard is not assessed as having improved and is often considered to be even less.

**What needs to change is the general attitude:** The motivation to understand what the consumer and carer are saying and the desire to want to communicate at the appropriate level needs to change at admission, inpatient assessment, discharge and outpatient review. The importance of getting this right at the initial presentation should be understood as this often fundamentally influences relapse and subsequent **outcomes (and therefore the costs)**. The understanding of the importance of mental health literacy generally through the community and especially within professional ranks needs to be addressed. Thus change is needed from the hospital staff right up through the system which would include the relevant Colleges of Psychiatry and General Practice, to the State and Federal Offices for Mental Health, and Offices of the Chief Psychiatrist.

**The Benefits of Change:** Any changes that influences the need for readmission, the length of stay in hospital, the time to get a functional recovery must be seen to better not only for

the consumer and the carer but dramatically influence the cost/economics of mental health. This is why it is so important to get this first presentation right, and to ensure that both consumer and carer fully understand the illness, and its possible course if full attention to the necessary details are not observed. Every relapse significantly influence the degree of total recovery on most occasions. Obviously if the **rights** of an individual are considered at all stages of the process every time then this has a considerable effect on the willingness of consumer and carer to fully engage with the medical advice.

#### TOPIC 2: IS THERE A PROBLEM WITH A STEPPED MODEL OF CARE IN MENTAL HEALTH?

**Assessment of Stepped Model of care:** From a consumer and carer perspective there is overwhelming feedback that there is a preference for having each case assessed individually. So again it comes back to the system of communication and the right of the consumer to be involved in each level of decision making and this is not currently being done systematically. Thus the stepped model of care therefore wrong.

**What needs to change:** Of course it makes clinical sense that if a level of improvement has not been reached then the next steps are considered, but it needs to be done with certainly the understanding of the consumer and carer. Thus this needs to be part of the understanding in all acute care hospitals and by all treating doctors in general practice. If it is considered that the consumer comprehends the reasons and can make a good judgement then the next step can be undertaken. Each step should have patient signed agreement. If however the clinical state of the patient is such that it is considered the said patient is at risk of a deterioration, other complication, prolonged illness and delayed recovery because the step is not agreed to by the consumer then a third party should be allowed after good discussion to make a decision on a change in therapy. Every step in the decision making should address the benefits of psychological therapy and include this if possible.

**The benefits of these changes:** There is no doubt that there is good evidence that good communication and observation of basic human rights at each stage significantly influences behaviour and compliance, and therefore helps the consumer to the fullest recovery. This therefore influences outcome perspectives.

#### TOPIC 3: HOW TO ADDRESS SPECIFIC HEALTH CONCERNS OF BOTH A GENERAL AND MENTAL HEALTH NATURE:

**The assessment of the consumer:** In addressing the need to know as much information as possible about a consumer then the rights of the patient need to be addressed. However if the consumer is judged to be in a state of reduced clinical awareness then there should be provision for the treating clinicians to approach other sources for information as well as perform necessary tests. At all stages an attempt should be made to approach a carer or other suitable person to get the information and to explain what is being done. It is known that consumers with many other comorbidities get mental health problems, e.g. cardiac, diabetic, metabolic, substance abuse, cancer, epilepsy, and these states can affect the cognition of the consumer. However at all times the consumer should be given the opportunity to be involved. Certainly the situation becomes more complex, as in a suicide attempt but the rights of the individual become even more important in these sort of situations.

## WHAT NEEDS TO HAPPEN?

**ASSESSMENT OF PATIENT:** Again it is clear that there needs to be opportunity to get as much information that is possible and therefore the consumer, the family and the carers need to be given full opportunity to say all that they feel needs to be said. Hopefully in the future "MY Health Record", once the confidentiality issues are resolved, will provide an additional provider of other important information. However the consumer needs to be happy for the family and carer to be involved.

**PREVENTION AND PROMOTION OF GOOD HEALTH:** Every opportunity to advise young people of the things that prevent mental health issues should be taken by a structured learning program that occurs right through their education. Because physical exercise is especially useful in the prevention and management of mental health issues then this should be understood and formally addressed. Vulnerable children need to be recognised by carefully worded surveys, or by the encouragement of other students to report concerns. Specially trained staff can then attempt to alter the course of potential emerging issues.

**BENEFITS OF INTERVENTION:** Preventing just one case of mental health is worthwhile. The prevention of one person entering hospital is worthwhile, not only by considering the cost of time lost by consumer, the cost of hospitalisation, but then the fact that every time someone enters the hospital system there is a risk of getting side-effects from medication, of an acquired infection and of recovery being prolonged. The prevention of one case of potential suicide is of inestimable value. Thus when one looks at the total value of prevention and health promotion the benefits are extremely significant and this should be identified at every level of government and decision making.

## **WHAT IS THE SIGNIFICANCE OF THE PRIMARY HEALTH WORK FORCE AND THE SECONDARY COMMUNITY AND CARER SUPPORT?**

**ASSESSMENT:** The primary health work force can be instantly divided into those involved with the direct treatment and management of consumers with a suspected or diagnosed mental health problem, and those involved in government and non-government policy making. It is obvious that a few will have some dual roles but they are in the minority. From a consumers point of view the issues are they do not feel that their scenarios are fully understood, and that decisions are made in which they feel that they are not consulted fully about or involved in the structure of. Similarly carers feel that they are often isolated, and that their part in the overall management minimalised, if not disregarded. The significance of this is that the consumer is not fully engaged with the treatment plan, and the chances of prolonged recovery and of relapse greatly heightened.

The part of the health system that is engaged in policy making urgently needs to be more in touch with the consumer, the carers, and the community. Although there is a feeling in the community that the health system has a far too large a bureaucracy for little demonstrable gain at the coalface, obviously we need an active policy making area which is in touch with community and consumer needs, and is active in integrating the various areas

like education, workplace, hospitals and community. They should also be proactive in absorbing the latest trends in world health and translating this into the local situation.

The total value of carers is greatly underestimated. They wear so much of the responsibility of the best progress of the consumer that often their own health suffers because of the lack of support and understanding by the health system. Carers are the backbone of care in mental health particularly and are instrumental in keeping the consumer well, decreasing the chances of relapse and re-admission, and complications like suicide. They often provide the necessary accommodation as well as being the link between the health professionals and the consumer whilst monitoring early warning signs of relapse.

**WHAT NEEDS TO CHANGE?** There needs to be a change at every level. The Chief Psychiatrist needs to ensure that all his primary care clinicians give due respect to consumers and carers at all times, and that at all times they finish each consultation with either the consumer and or the carer, or both, being better informed and feeling understood. The primary care clinicians need to be trained from medical school on that these are the goals and then only need subsequent reminders at the regular clinical reviews that this is a primary goal. Clinicians in emergency particularly need to be reminded that sometimes acute mental health presentations may mimic substance of abuse presentations with the consumer appearing irrational and showing little insight to what is occurring.

Further the Office of the Chief Psychiatrist needs to be directed to prioritise that the rights of the individual need to be considered at all times in policy making and to understand its relevance to best practice, best outcomes and to the improved understanding of the community to the causes of mental ill-health.

**BENEFITS:** Again the same benefits of better outcomes, shorter hospital stays, and better results for the individual and their carers will be achieved.

## **WHAT IS THE SIGNIFICANCE OF HOMELESSNESS AND HOUSING TO MENTAL HEALTH ISSUES?**

**ASSESSMENT:** Housing needs are associated with both the cause of mental illness and also to the complications of mental ill-health. However of equal significance adequate housing is certainly associated with better outcomes and better recovery. Providing housing of course is only one factor in the equation as at all times the consumer needs to be able to be able to cope with other factors associated with good daily living like transport, food, and proximity to other support systems including medical advice.

**WHAT NEEDS TO BE DONE:** One of the most significant priorities to look at the housing for consumers with severe, persistent, and complex problems, like schizophrenia. The reason for this is that the carer needs to have some respite themselves from what is prolonged, challenging stress, that in the past required these cases to be committed to asylums and long-term hospital admission. There are many other cases that also need to be prioritised by their effect of their illness on other people in the community. It should not be difficult to establish a national or regional state priority guidelines for this based on judged severity of

illness, number of relapses, ability to cope by themselves, and support systems.

The way governments can help is by using un-occupied buildings for consumers with chronic illnesses. This brings them into a common area where it should be easier for some supervision, and this will be more central for transport and other social needs to be met.

**BENEFITS:** The benefit immediately will be that it will more easy to judge the efficacy of programs being implemented in the treatment of an individual. There should be a significant change in the prejudice and intolerance perceived in the community. The health of the carer will improve significantly as well.

#### **OTHER QUESTIONS FROM ISSUES PAPER:**

The assessment of the other questions has not been dealt with.

- a) Income support and social services.
- b) The facilitation of Social inclusion and participation.
- c) The numbers in the Justice system.
- d) Child safety aspects.
- e) The effects on education and training.
- f) Government funded employment for carers and consumers.
- g) Mentally healthy work-places.
- h) The integration and coordination of services
- i) Funding arrangements
- j) The assessment of outcomes.

#### **INCOMPLETE REPORT**

Unfortunately time has prevented me from finishing the submission fully as I have two Japanese families visiting for a week. If so requested I will complete early next week but I wanted to get this into you as an example of where I see things from a general practice and a carer's perspective.

#### **SUMMARY OF PRIORITIES**

- 1) There needs to be a marked paradigm shift in the understanding at every level of the community.
- 2) It needs to be understood the numbers affected at any one time, and that much of the illness is under the surface, and that we only see the tip of the iceberg. However there is a significant effect on the cost to the individual, the carer and to society that is not apparent. This is extremely large in health economic terms.
- 3) It needs to be recognised that there is a continuum from birth until end of life, and that prioritising mental health in children will go a long way to influencing future outcomes.
- 4) There needs to be action to reduce inequalities there is evidence that social and economic inequality drive poor mental health.

- 5) There is also a need for action on the social determinants of mental illness in the lifestyle factors of alcohol, and substance abuse, and then the secondary effect of these leading to further health problems.
- 6) There needs to be an understanding that mental illness is associated with a reduced lifespan not only from suicide and that this has significant effects on the whole of society.
- 7) The warning signs of mental illness need to be addressed sooner as it is clear that outcomes are directly tied into early treatment. Psychological therapy needs to be prioritized in this. However this needs to be urgently revamped as outcomes are not sufficiently bound into each session leading often to prolonged therapy.
- 8) The possibility of genetic factors should be known by all treating professionals and its significance noted.
- 9) The consumer and the carer must be prioritized at all times in the discussions and therapy as it has been clearly associated with compliance and better outcomes.
- 10) Recovery should be prioritized as there is a far too big a gap between discharge level of functioning and that needed for functioning in the community often leading to readmission.
- 11) The destigmatisation of mental illness must remain a priority and must occur at every level of society.
- 12) All therapist must become more transparent, and less defensive in their communications, and at all times mental health literacy needs to be considered and applied.
- 13) Money should perhaps be taken out of areas where outcomes are not seen, even though this is sometimes in the areas of mental health bureaucracy.