

Submission to Mental Health Enquiry, Productivity Commission

I have viewed the Productivity Commission Issues paper on “The Social and Economic Benefits of Improving Mental Health” . I have found it well organised and asking appropriate questions regarding important matters.

I am submitting this as a recently retired clinical psychiatrist who cares about mental health problems. As a doctor I will talk about “patients” rather than “consumers”; my training has been about mental illness but for this I have to understand about mental health. I found Figure 1 an excellent diagram showing how improvements in mental health can benefit both individuals and the wider community.

My comments are not across the whole paper but are concentrated on section 3 “Contributing components to mental health and wellbeing”; I will aim to give the page number of each item I discuss.

Pages 11 to 14

Mental health care plans can be devised for intervention plus research or as a care plan for individuals with mental illness.

The former where research outcome is measured is valuable for our knowledge about what helps. All too often though it is unsuccessful because of underfunding and lack of good research methods.

Individual mental health care plans have more chance of success and follow-up if a substantial mental health team is present. Wrapping a “supportive network around the individual consumer” is a critical part of intervention as is mentioned in the paper.

Mental Health plans arranged by general practitioners bring together a team of mental health professionals (such as psychiatrist, psychologist, social worker etc.) plus of course the GP who coordinates the care.

<https://www.healthdirect.gov.au/mental-health-care-plan>

This can work well as long as communication is made between team members so that they each understand their particular role. There is also shared support and supervision often vital when dealing with certain mental problems. The patient will feel cared for on many different levels.

Rural and sole caring professionals do not often have the luxury of other mental health workers nearby.

As mentioned on Page 12 there can be “fragmentation and limited coordination across services, providers and settings, rather than a genuine mental health system”. A single care plan should be readily available to potential carers as the ill person is not always able to recall all the details especially in an emergency.

As mentioned on Page 12 services are unfortunately “designed with a focus on the needs of providers rather than consumers”.

This particularly applies to appointment times, the physical situation of the service and transport availability, and the navigation of services such as Medicare and Centrelink.

The above items can be hard enough for healthy individuals with available income but can become further stressors in more fragile individuals.

On page 14 the concerns about “Mental Health promotion, prevention and early intervention” are discussed.

Unfortunately attitudes to and knowledge about mental illness can be limited and require a lead from above ie. from government and all those with positions of power. There is still discrimination against people who are mentally ill.

This also extends to some of the medical profession who regard the specialty of Psychiatry as a “poor relation” where funding and attitudes lead to other medical problems seeming to be more important.

Psychoeducation is therefore most important helping patients themselves, their families, friends, schools, colleges work places, Churches and generally throughout the population.

Discussions about normal and abnormal mental health including suicide breaks taboos and puts a light on what was once a dark place; this is much healthier.

Page 17

Frontline work can often be stressful for mental health workers and informal carers; they need to debrief after serious incidents. There should be regular time allowed for talking about the presenting problems and how they can manage these. At this form of supervision adequate attention must also be paid to how the worker and/or carer herself is feeling. Sometimes workers feel anxious because they do not understand a problem; further and continuing education on mental health and illness should be a given part of the job. This will help the worker and therefore the patient. Knowledge strengthens the workers and carers.

This problem can be worsened by isolation and physical distance. There has to be online and telephone assistance readily available plus visits by therapists particularly trained in psychoeducation for staff and patients.

Mental health teams composed of a number of allied professions have the benefits of specific professional knowledge but also the overlapping of therapeutic skills. Ideally one or two of these members will have particularly good communication skills and can act at the interface between the therapeutic team and the patient and his carer, family, and social group. This may mean travelling to remote areas to give support

and knowledge plus details of the mental health plan. It may also involve helping patients to navigate forms and interviews for example for funding for transport, for applications for NDIS or Centrelink support etc.

Pages 18 to 19

A roof over a person's head would be considered to be an essential right in this country. No therapeutic interventions can successfully and thoroughly assist a person who does not have this.

As mentioned social housing needs to be flexible to respond to the needs of people with various and fluctuating mental health problems so that they can move seamlessly between living independently, to living in sheltered housing with care available not far away or actually in the house to therapeutic communities to actual hospital. Times required at any of these levels have to be different for different people and allowance to stay at one level is also necessary.

All these types of housing need to be integrated within the general community so there is no separation and alienation.

Pages 24 to 25

As mentioned there are elevated rates of mental illness in young people that have left out-of-home care. Children do not automatically mature into adults at the age of 18. Where fostering has been a successful experience continuing care and contact can be fulfilling for all concerned. A family who are still there for a young person can help them to start and continue further training or tertiary education and also help them with leaving school and moving straight into a job. These are all major events in a young person's life and can be eased with family support. Continued payment and help may be required for these foster families.

Regarding "Education and Training" absenteeism from school can lead to future problems. It can occur because education is not valued in the home or because of lack of motivation which may be a symptom of underlying mental illness such as depression or anxiety; specific and maybe undiagnosed learning problems can also lead to absenteeism.

<https://espace.library.uq.edu.au/view/UQ:0d04c8a>

Classrooms in schools and other places of learning and training need to be flexible for specific needs so that anyone who is feeling emotionally low or dysfunctional can remove themselves to a 'safer place'. This helps young people to take responsibility for their emotions and hopefully removes the risk of "acting out" behaviour with its possible adverse consequences.

In this document I have only been able to touch on a few of the many factors involved in mental health care.

There are many ideas and interventions required to achieve better mental health but it is a sign of a good society that we are always striving to improve the care of our people.