2019 Submission - Royal Commission into Victoria's Mental Health System

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What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?
"This submission is primarily based on my experience as a clinical psychologist working predominantly with children, young people and families, and is also informed by research positions I have held, and by my own experiences of being a client and of growing up in a family where each member had at least one mental illness, including severe mental illness, and where outcomes were tragic. Hence my request for anonymity. The main reason I wanted to make this submission is to underline on behalf of clients and professionals that the gap is large and dangerous between what can be treated under Better Access to Mental Health and what can be treated by the public area mental health services. I have also attempted my best responses to the 11 questions. Recognise that research shows that there are limitations associated with awareness-raising campaigns portraying mental illness as being just like physical illness this view has been associated with unfavourable perceptions of people with mental illness. Mental health literacy initiatives need to be conducted with acknowledgment that many clients and professionals have valid critiques of the DSM-5 perspective. Also there are issues with raising mass awareness about the threshold for help-seeking when the services are not sufficiently available. Often writing/ speech about people with mental illness is in grave tones suggestive of a seriously disabling condition with poor prognosis. Similarly when the term consumer' is used it often appears to relate only to more severe presentations. We need to introduce lay terminology equivalent to the words high prevalence disorders' such that lower levels of disturbance can be distinguished from severe mental illness and then people will be less reticent to identify as having mental disorder (to themselves and others) and to seek help, if all mental illness does not come under one banner with weighty associations. A public awareness-raising campaign could help Victorians understand the range of different severities without merely splitting into high prevalence disorders and low prevalence disorders/severe mental illness. "

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
"Prevention working well the work of VicHealth What can be done better to prevent mental illness: -Social inclusion policy implementation Family strengthening policy implementation Supporting parents in building attachment relationships and in learning and implementing parenting skills -Genuine implementation of school-based wellbeing and resilience programs, emotional intelligence programs, and bullying prevention -Drug and alcohol culture shift and service reform - Reducing socioeconomic inequalities, reducing housing stress, improving working conditions - Improving aged care conditions What can be done to support help-seeking: Reduce stigma - Improve referral pathways and reduce service system fragmentation -Fund treatment properly so people will become aware of the improved efficacy and more inclined to seek help -Adolescence is known to be the most common age of onset of mental illness across the lifespan and early intervention at this stage is critical, however the traditional pathways to help are

problematic. For youth it can be a limitation that the main service options are education-based (due to stigma), or health service-based (due to youth being physically healthy, not often in need of medical services, and not identifying as sick when having disturbed emotion regulation). Stepped service delivery options starting with non-threatening approaches need to be available. For example, in secondary and tertiary education there could be wellbeing-type coaches who engage with the students applying useful and evidence-based practices (e.g., stress management, mindfulness, study skills, growth mindset theory, careers counselling, and strategies supporting development of grit and perseverance), which could play a preventive role and also be a de-stigmatised entry point to the school counsellor or private mental health professional referral when needed and more clinical services combining medication and therapy when needed. Any referrals at this age (when identity development is at the fore) need to convey that vast numbers of Australians access services relating to mental health and that mental health problems most often do not persevere throughout the lifespan, especially when action is taken. "

What is already working well and what can be done better to prevent suicide?
The recommendations of researchers in the suicide prevention area need to be fully funded and implemented instead of the current state of patchy translation into practice. We need to consider the role of our national culture and look overseas to countries that are doing better. One of my closest family members died by suicide after over a decade in the mental health system and there are no easy answers to this question. One point would be that youth need to hear personal testimonies from respected and relatable public figures attending mental health professionals and getting better. It may also be helpful to hear stories from people slightly older than them who attempted suicide and later regretted the attempt.

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.
"It is very difficult to know what makes it hard for people to experience good mental health and what can be done to improve this, and I believe most of the answers lie outside of clinical mental health services. Regarding how people find and access mental health treatment, when referring loved ones and clients, I have experienced the array of services to be a bewildering rabbit warren, with many wrong doors. There should be no wrong door to getting mental health treatment. Regarding how people experience mental health treatment and support, this would improve when: clients' meta-beliefs' about what it means to be in mental health treatment are transformed by a cultural shift away from regarding this as shameful, rare and indicative of a poor long-term prognosis -professionals learn to prioritise the therapeutic relationship (above the treatment type and other variables) and are supported to have strong therapeutic relationships by the services and systems they are part of, characterised by an ethos of care, respect and trustworthiness services are fully funded to reach the best possible outcomes for each client therefore hope of improvement is realistic. Regarding how services link with each other, the most critical point regarding linkage of services is that the drug and alcohol sector and mainstream services obviously need to be better linked, if the Commission establishes that they should remain as two sectors not one. Generally, I have observed that services can link poorly with one another following competitive tendering and mutual dissatisfaction with each other's intake processes especially regarding the proportion of clients that services turn away. Workers can be so busy with their client loads that they do not take the time to build their knowledge regarding other services and to make referrals (very time consuming and often fruitless), and this is understandable

because the service system is so fragmented and fluctuating, an unfeasible number of hours is required to establish and maintain familiarity. "

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

"It is much harder for mental ill health to be treated in the context of housing issues, justice issues, poverty, social exclusion, racism and discrimination, and drug and alcohol issues, pointing to the need for redressing inequalities and preventative efforts in all these domains and services that are working together not in silos. "

What are the needs of family members and carers and what can be done better to support them?

"Fully funding mental health treatments and removing hurdles to navigating services will be the best thing for family members and carers - to bring about the best mental health outcomes for clients and thereby minimise the stress and suffering within families. Improved continuity of care also would ease stress. -Strained family relationships both contribute to mental illness and result from it. Supporting Victorians to have strong family bonds and skills for dealing with family life is relevant here. Information and support should be readily at hand for family members to use when discussing mental illness within the family, just as information is readily available about how to have a conversation with someone who has suicidal thoughts. Professionals should be allocated time within their roles for liaising with family/carers, within the bounds of confidentiality. Regarding confidentiality as a potential limitation for meeting the needs of family members and carers, I'm not aware if research has been done within ethics to truly know what is in the client's best interests. For example, I suspect that research questions have not been explored around whether young clients fare better in terms of outcomes when professionals do not communicate at all with family members, compared to when professionals seek consent to give broad feedback to family members and information about how families can best manage the relevant issues. "

What can be done to attract, retain and better support the mental health workforce, including peer support workers?

"I have not observed any issue with attracting the workforce but support and retention are problematic. There is the need for: -Support to translate research into practice to achieve outcomes that are gratifying to the client and therefore the professional more funding of translational research, building practice-based evidence, clinician-driven affordable professional development programs and support with implementing learnings. -Attention to career progression and work conditions. Flat hierarchies are often not desirable but in the mental health profession seniority is often not desirable because it involves more responsibility for life and death situations and dilemmas about distribution of insufficient resources. -More opportunity for varied careers spanning multiple parts of the sector. -In pointy end' services with multi-crisis caseloads, there is a clear need for stronger team support (which relates back to HR conditions) and sufficient funding such that professionals have the time to adequately treat clients and are not pressured by throughput demands to discharge them before the client is ready. The work of a mental health professional is more fulfilling when not having multiple clients on one's caseload who are in crisis simultaneously, however this can be manageable with adequate structuring and resourcing. -Support for the future psychology workforce with more thorough training starting from the undergraduate phase. Currently the curriculum of postgraduate courses is packed with broad coverage of a vast number of areas, however undergraduate psychology major curriculums have

been lacking in mental health content (being based on the science of behaviour in the broadest terms and heavily statistical). This has improved marginally in recent years but there is a huge missed opportunity here in the undergraduate phase for teaching regarding wellbeing and positive mental health, mental illness (aetiology, assessment and treatment options) and basic counselling skills. This would also help with attracting a suitable workforce as the students would have the opportunity to be exposed to the relevant content before deciding whether to pursue a career in the mental health profession. Psychology is the only discipline within the mental health professions in which students need to get to fifth year before seeing a single client. -Support and expansion for peer support worker programs and integration in the broader system. -There are specific issues for the workforce seeing children, young people and parents as a psychologist under the Better Access to Mental Health Medicare scheme which causes many psychologists to cease doing so see Question 11 points 3-5 below. "

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

"There are many opportunities to support the social and economic participation of Victorians with mental illness. One area of need I have noticed is when working with young people who missed all their schooling from early high school onwards due to anxiety-based school refusal (including bullying), their opportunity for full social and economic participation is extremely limited. The Department of Education and Training could offer some innovative solutions here for those who have had a long-term lack of success re-engaging with schooling, perhaps using predominantly online delivery of curriculum."

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

"As above, there should be no wrong door to accessing mental health treatment. This sector needs a nothing about us without us' movement. I have some points to make regarding my main area of work which is seeing children, young people and parents as a psychologist under the Better Access to Mental Health Care Medicare scheme. If this scheme is retained as a major component of the mental health care landscape which is a legitimate topic for debate then several points are worth considering. This is a hugely important area of opportunity for early intervention, yet presents several systemic challenges for clients and therefore psychologists: 1.The first challenge for treating a child is needing a GP referral with the child present at the GP appointment as the identified patient', when sometimes the parents/guardian would rightly prefer to raise and discuss the issue without a young child present. There is also the issue that the child needs to have a mental disorder diagnosis under ICD-10 on their health record in order to be eligible for the treatment, which can be a deterrent. I have had some parents pay the private full fee for sessions because the GP has told them there could be life-long issues for the child due to having a mental illness diagnosis on their health record, in unforeseen ways (along the lines of not being eligible for insurance or not being able to join the army). 2.Best practice for many issues is to have some sessions with the child present and some with the guardian/parent(s) without the child present, however the Better Access to Mental Health sessions are intended for the child as the identified patient and not for parenting sessions. 3.The number of sessions is not sufficient to treat most children/youth 6 or 10 under exceptional circumstances especially when most present with multiple issues. Even short-term manualised evidence-based treatments such as CBT for anxiety typically require around 16 sessions to work through. 4.Working systemically (ie. liaising

with relevant school staff, other health and community sector professionals and supports, and family members) is often best for a child but I do it as unpaid work when a child is a patient under Better Access to Mental Health. Most psychologists I know reluctantly cease this kind of systemic work. 5.In terms of severity levels, there is an unsafe gap between what Better Access to Mental Health is suitable for and referrals that the public area mental health services will accept. This leaves a large client group who need much more than 6-10 sessions (and potentially a team-based approach) and yet are not deemed severe enough to get through the CYMHS/CAMHS intake process, and this thereby leaves their psychologists concerned about clinical responsibility for this client group without being sufficiently resourced and supported to give them the services needed. I have had clients discharged from CYMHS to me under Better Access when they are still suicidal, psychotic and self-harming. I have had CYMHS and CAMHS not accept my referrals of suicidal clients on grounds of insufficient severity. I have also been reprimanded by intake of one such service about not referring a suicidal client sooner and then they discharged that client after one session on grounds of insufficient severity for their service. I tend to find that CYMHS and CAMHS do not try hard to engage hard-to-reach' clients and then these clients express reluctance to attend and then when I follow up the service tells me that they withdrew consent. If CYMHS and CAMHS were sufficiently funded to work with multi-crisis disadvantaged families (including the outreach required), they would do better at engaging these clients and consent would not come into question. Colleagues of mine have ceased to work with children due to these limitations (especially points 3-5), preferring taking referrals for adults only. ATAPS is supposed to go some way towards addressing the above concerns but colleagues of mine tend not to use it, not wishing to bulk bill. GPs also often do not know the difference between referring under ATAPs and Better Access leading to the wrong paperwork. "

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?

"-Sustained funding increases in the abovementioned areas -The reform process needs to be driven by consumer expectations and consumers need to be given permission to have expectations in this long neglected area and a commissioner needs to be available and known to consumers to report to. -Victoria needs to build a diverse mental health workforce which is reflective of the diversity of the Victorian population, for example, via tertiary scholarships and supports for an increase in the number of mental health professionals with indigenous and refugee backgrounds. "

Is there anything else you would like to share with the Royal Commission?

"Having had one of my family members die due to alcoholism weeks after discharging themselves from rehabilitation soon after being admitted, I struggle to understand why inpatient units can hold patients involuntarily if they are dangerously psychotic or suicidal, but rehabilitation units cannot hold patients involuntarily if they might be about to die due to addiction. I think our society needs to have a debate to ascertain whether we are comfortable to accept such outcomes as implications of our civil liberties in this area. "