

PRODUCTIVITY COMMISSION INQUIRY INTO MENTAL HEALTH 2020

OVERVIEW

WHY THIS ENQUIRY?

1. **EARLY HELP FOR PEOPLE:** Perhaps the biggest gap or anomaly in our mental health system is that early help is delayed or more directly that more has not been done to prevent mental illness. Almost certainly the best help for people is to be brought up in an environment of consistent love, support, peacefulness and stimulation, and where there is predictability, transparency and rationality in behaviour in their associated family. In fact the optimising of the pre-conceptual and post-conceptual environment is considered to be important in providing the best state for developing optimal mental well-being even earlier. Thereafter parents and carers must be alert to when a child is behaving outside of what is considered to be an acceptable range of behaviour despite being given consistent love, food, comfort, and tranquillity. Once past childhood the educational process must reinforce that all people are equal, have rights, are accepted and are a desirable part of this fortunate country. After such a beginning then following the completion of education, each part of our future societal existence, whether it be in the workplace, recreational, or other environment, pathways must be prioritised for referral of consumers considered to be struggling. All of us have this responsibility to make sure that we not only optimise our own well-being throughout life but are alert to guiding others to the earliest help possible.

2. **IMPROVING PEOPLE'S EXPERIENCE WITH MENTAL HEALTHCARE:** Fore-mostly we must ensure that every person that comes to work into any part of the health system has been selected appropriately, and gets a regular enthusiastic guidance invecives to maintain an optimal attitude. The next dilemma which consumers and carers both face is not being 'fully' listened to. Consumers and carers must come away feeling that they have been acknowledged, and treated without bias, and that their full human rights have been invoked.

3. **IMPROVING PEOPLE'S EXPERIENCE WITH SERVICES OUTSIDE THE HEALTH SYSTEM:** This is why there should be a mental well-being consideration in all policies and in all parts of our society. It should be led from the top of Government, and flow through every modality of society. There is enough evidence to suggest that if a person is feeling on 'top of their game', that is mentally well, then they are far more likely to work well, perform well, integrate well, be innovative, and show loyalty. More specifically people who are mentally unwell have a reduced capacity to get tasks done and have reduced ability to tolerate decisions, challenges and difficulties. The lack of transparency, the delays in addressing important issues all seem to impact more on people who are unwell and often cause delays in their recovery. Thus all services like housing, councils, transport, etc., need to be alert to this, and staff trained regularly with this regard.

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4. **INCREASING PARTICIPATION OF PEOPLE WITH MENTAL ILLNESS IN EDUCATION AND WORK:** Places of education and the workplace should both be able to address the return to participation by graduated recovery programs that have been fully discussed with the consumer and carers involved. Both the places of education and the workplace as well as the consumer should know that this optimises the likelihood of full mental recovery, decreases chances of relapse, improves integration with others, and decreases the loss of knowledge and skills in the process. Dedicated people in all institutions should be available to guide this.

5. **REFORMING THE FUNDING AND COMMISSIONING OF SERVICES AND SUPPORTS:** Firstly it must be clearly and unmistakably understood by all individuals as well as by all services and supports that it is in their own interests to take on the responsibility for optimising mental well-being and recovery. Obviously consumers will fall outside of a supported system, and again the funding should be shared equally from across the various portfolios of government. That is why there must be a mental well-being policy in all areas. Everyone must see that optimum mental well-being benefits every part of our existence, every government department and every person.

THE CASE FOR MAJOR REFORM

1. INQUIRY BACKGROUND AND APPROACH

1.1 **WHY THIS INQUIRY?** From the findings of the World Health Organisation, the release of the 'Connections Conversation' by the National Mental Health commission, and the knowledge that despite increased funding being allocated into various aspects of mental health for some time, we are faced with increasing mental ill-health, increased suicide, delayed recovery, a society with less skill in handling adversity (decreased resilience), and increasing socio-economic problems (increased crime, consistent road-tolls, suicide, substance abuse, and generally possibly a more unhappy, intolerant society (although this is difficult to qualitate and quantitate). It is urgent that we take this opportunity to totally reform our mental health system.

1.2 **WHAT AFFECTS AUSTRALIANS MENTAL HEALTH AND WELL-BEING?** Apart from the obvious individualised genetic endowment that we all get, the consistency of a favourable environment during growth and development would be the next most significant factor. A strong family connection where love, support, understanding, acceptance and forgiveness is regularly provided is extremely beneficial. It can also be argued that the pre-conceptual and post-conceptual periods are important in establishing the best environment for child mental well-being. On the contrary where there is loneliness, homelessness, lack of consistent comfort, food, friendship, understanding and support the frequency of mental illness rises consistently. Thus the social determinants of health need to be up scaled in their importance, as they are closely associated with mental ill-health.

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1.3 DEFINING THE SCOPE OF THE INQUIRY: Having an inquiry about something that is well recognised has to go beyond re-affirming the hypothesis that the current mental health system is not working. The inquiry obviously must address the efficient ways of instituting a reform program which is a total transformation or metamorphosis of how we have been going about it.

However because plans have been devised in the past there is a need to address why these have been limited, why reforms haven't occurred, and why so often plans are not guided through to finality or effectiveness.

1.4 THE FEEDBACK FROM THE COMMUNITY: As far as I can see considering the United Nations convention, the World Health initiatives, feedback from consumers, carers and workers in mental health is that they all consider a more social model for health, especially mental health, is required that addresses equality for all groups including disabled, disadvantaged, immigrants and sufferers, that considers all the social determinants of health, and is placed under the health umbrella.

Many consumers report that they have experienced trauma in the current mental health services. They feel that so often their full rights of citizenship are ignored, for example they may not be offered the full range of treatments available. The other significant report was that they feel that they are not being listened to, and carers report a similar story. Finally they are sometimes bewildered by being discharged without the coping skills into an often unfriendly or unresponsive community environment and this contributes to a much delayed recovery, and increased likelihood of re-admission.

1.5. DEVELOPMENT OF A REFORM AGENDA TO RESPOND TO COMMUNITY CONCERNS: One can understand that in the past that it has been felt necessary to go to the top of the echelon, the professorial departments and chief psychiatrists to initiate such reforms. The consumer, carers, and primary mental health workers on the coal face however have a wealth of knowledge and insight into what works, and this must be absorbed. Thus listening to consumers and carers, and responding with transparency, good communication, opportunities for involvement and feedback are required.

2 AUSTRALIA'S MENTAL HEALTH

2.1 THE PREVALENCE OF MENTAL ILLNESS IN AUSTRALIA. Of course what is seen is in reality the tip of the iceberg. When one understands that illness or dysfunction is only one step away from normal well-being, then one gets a picture of why the system must change. There are so many more people who could function better.

2.2 WHAT IS THE REDUCTION IN YEARS OF HEALTHY LIFE LIVED DUE TO MENTAL ILLNESS? Any time when a person is not at the best mentally is of course not living healthily. The longer the delay in getting help and the more severely unwell the person is, then the more likely the years of healthy life is reduced for the same age range.

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2.3. DIFFERENT GROUPS HAVE DIFFERENT NEEDS AND OUTCOMES: Absolutely different groups are exposed to different challenges by their environment, cultures, religion. Each group must have their appropriate human rights addressed, and as far as possible get equal opportunity to health reforms. Each group has its own inherent responsibilities in ensuring optimum outcomes.

3. WHAT MENTAL ILL-HEALTH AND SUICIDE IS COSTING AUSTRALIA

3.1 IMPACTS OF MENTAL ILLNESS AND SUICIDE: The impacts are of course not just on the individual in days lost in quality life, but are spread right through the community, to family, friends, workplace and other associates. Not only is there an impact on the workplace but impacts can be seen in those who fall under the influence of the consumer. Full impacts are at times difficult to evaluate, especially if the consumer themselves was a significant carer to another person or was a significant contributor to society. In suicide the impact can of course cause ill-health or even copy-cat circumstances.

3.2. MONETARY COST OF MENTAL ILL-HEALTH AND SUICIDE: This is of course difficult to put exact estimates of cost, because many suicides on the road and in the workplace are not recorded as such. Similarly a person who is depressed who has a heart attack may be recorded as just a heart attack. Also there are significant costs in the workplace, sporting and other recreational areas. The cost of re-training, working understaffed, and working at a lowered efficiency and a level of enthusiasm should all be considered in the equation.

3.3 LIFETIME IMPACTS OF EARLY SETBACKS: These are particularly significant not only in the formation of poor mental well-being in the affected individual but in lifetime behaviours which impact on others. It is well established that children who have witnessed their mother being abused or have been abused themselves, have an increased likelihood of abusing someone themselves in the future, or suffering other abnormal symptoms. Similarly children exposed to suicide can be influenced significantly.

4. THE WAY FORWARD-CREATING A PEOPLE ORIENTED SYSTEM:

4.1 THE GOAL- A PEOPLE ORIENTED SYSTEM. To establish this then we prioritise the prevention side of the reform process. And to do this we have to significantly bring the whole community on board with direction from the Minister for health and the Prime Minister. The entire country must be on board. Consumers must feel that they are guiding the reform and one of the ideal sources of experience are the associations of consumers with lived experience (like LELAN).

4.2 EMPOWERING CONSUMERS TO TAKE AN ACTIVE PART: When consumers feel that significant changes are being made to the medical diagnosis/therapy dominated system, and that they have a consistent voice, then worthwhile progress will be made.

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They have to know that their full human rights are being observed. All societal groups must feel that they are an equal part of these changes. Good transparent communication must be maintained at all times.

4.3 SYSTEMIC CHANGES NEEDED TO CREATE CONSUMER-ORIENTED SYSTEM: The government must direct the AMA, Colleges of Psychiatry and General Practitioners, Nursing federation of the direction that it wants to move, and request that they plan accordingly. They must be given strict time expectations preferably 6 months and at most 1 year. Prevention of mental illness must be seen to start with a parental responsibility to ensure the optimum healthy well-being of themselves and their children. All medical personnel including general practitioners, nurses, pharmacists, all medical care workers and all educators must prioritise the mental well-being of children right through to their maturity. Similarly all sectors of society including all recreational, entertainment and workplace enterprises must put mental well-being at the forefront of their endeavours.

PART II: RE-ORIENTING HEALTH SERVICES TO CONSUMERS

5 PRIMARY MENTAL HEALTHCARE

5.1 GP'S ARE THE FRONT LINE OF CONSUMER FOCUSED CARE. The direction for this to occur must start with their selection to do medicine. Consideration should be given to have specifically mental health GPs either as a primary course, or as a extra course tacked on to their degree. The medical course must not be seen as a money-making career. Extra wealth should come from hard work as in providing a service when demand dictates. Good mental health oriented GPs would obviate the need for more psychiatrists and also open up more specialist appointment time. It should be supported by better specialist support via communication access and technology. This would provide better efficiency for both GP and specialist.

5.2 MATCHING CONSUMERS WITH RIGHT LEVEL OF CARE. Technology should be used to allow consumer feedback to ensure consumers feel they are being heard, as well as to provide alerts to inappropriate treatment progress. Similarly GPs should be able to give feedback so that the right level of care can be judged.

5.3 IMPROVING PSYCHOLOGICAL THERAPY TO MEET CONSUMER NEEDS: *Warning. Dramatic blowouts in budget possible***.** If the psychotherapy arrangements are not established clearly then there will be a dramatic overuse of the therapy. All people like to be noticed, cared for, and talking to anyone usually helps. The way universities are marketing psychology, and churning out psychologists without definite pathways for integration into society/workforce, then to make a living, is of some concern. These psychologists will then be tempted to over-service in the sense that they can easily argue any consumer can always benefit from another session. Of course psychotherapy is very important, and in many ways it is preferred to medical therapy. However I think two things must occur.

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There must be a far better way established to judge beneficial improvement from the therapy with some consumer responsibility in this, and there must be a way of preventing over-servicing. If a therapist wants to see a particular consumer more then there must be perhaps a reducing scale of payment, or the consumer should be willing to pay more (like any other commodity they need. Like medication, cigarettes or alcohol). Perhaps, a better way to use psychotherapists would be to involve them early in family situations, and early in the educationary system far more.

6 SUPPORTED ONLINE THERAPY

- 6.1 WHAT IS SUPPORTED ONLINE MENTAL HEALTH THERAPY? One example is the availability of a GP to contact and speak to a specialist, usually a psychiatrist to discuss a case, either in the presence of a consumer or confidentially. This can be done on the phone or by video linkup with or without the consumer present. It is used when the symptoms and signs are outside of the GPs experience, in emergencies, and where the specialist has seen the patient before and wants to assess progress. It is of course of increased benefit for rural GPs and to those offering out of hours care. Another form would be a primary consumer support/advice service.
- 6.2 WHY FOCUS ON SUPPORTED ONLINE THERAPY? Rural GPs have to often handle a wider range of problems and specialist services are more difficult to arrange, so increased rural support is necessary, especially on a background of increased mental illness and suicide in these areas. All GPs, not only those especially interested in mental health, would benefit from being able to discuss with a specialist a case in a) emergency situation and b) in a non-urgent situation.
- 6.3 BENEFITS OF SUPPORTED ONLINE TREATMENT. All GPs, not only those especially interested in mental health, would benefit from being able to discuss with a specialist a case in a) emergency situation and b) in a non-urgent situation. This would allow more efficiency, better outcomes, better job satisfaction, whilst freeing up considerable specialist time. It could free up hospital outpatient times. Online pharmaceutical advice would be valuable and prevent possible drug interactions, whilst optimising dosages.
- 6.4 WHAT COULD LIMIT THE TAKE-UP OF ONLINE TREATMENT? The provision of appropriate technology skills as well as internet services would of course limit the take-up especially when the GP is travelling in remote areas. The availability of specialist services when they are urgently needed of course sets a limit but central call areas may overcome this (as per ambulance services). Increasingly all GPs should be technically proficient, but the medical course should be able to ensure proficiency in the future. A primary consumer support service might be limited by having a too high a demand.
- 6.5 ESTIMATING THE GAINS OF EXPANDING SUPPORTED ONLINE TREATMENT. All rural GPs should be able to estimate the number of mentally unwell patients they see, they number they refer, and the number of suicides. Pharmaceutical record should be able to indicate how many rural consumers are on psychotropic medication. If such a service improves

consumer outcomes (recovery), limits consumer transfer and times spent in a mental health facility, and lowers the suicide risk then it would seem favourable.

However in the metropolitan areas, and large towns, GPs access to an efficient supported online service should increase specialist appointment availability and decrease waiting times.

7 SPECIALIST COMMUNITY MENTAL HEALTH SERVICES:

- 7.1 CONSUMERS MUST BE MATCHED WITH THE RIGHT CARE. All societal groups must be catered for and this might mean that some consumers have to travel to more appropriate centres or that a suitable specialist may need to be arranged for them at their local service. Feedback, perhaps using appropriate technology (e.g. phone app) might help in this matching process. The emphasis is on consumer feedback to get this right.
- 7.2 THE MISSING MIDDLE. Again the selection of personnel is important. All mental health personnel need to have assessments of their own well-being and health. It is important that all community centres have an intermediary social worker trained in mental health who can ensure all consumers get support when it is needed and who can triage cases. Improved feedback to the associated GP must be optimised by way of better, more immediate, summaries and protocols sent back to GP. These protocols should have to be acknowledged as received. Likewise all GP referrals should be acknowledged as received and acted on.
- 7.3 ADDRESSING THE GAPS IN COMMUNITY SERVICES. The gaps certainly exist. **Example patient history.** One patient went for blood test on one day, advised service that she was down to last tablet of important daily medication, told that no doctor available to write prescription, was advised to return on next day for results and prescription, on return next day advised prescription not done and advised to go to pharmacist and wait. At pharmacy waited until closing time and still didn't receive necessary medication, and so panicked! **Another example.** Early warning signs not picked up in a case by mental health worker nurse visit to consumer with rapid-cycling bipolar illness where patient was talking more frequently and rapidly, was buying unnecessary items, and was not sleeping as much. This resulted in hospital admission, and prolonged recovery. **Summary:** Perhaps the biggest factors are the correct selection of personnel, and a lack of the necessary staff numbers. Also the directors of community mental health services do not seem to have any skills in management of staff, and how to run an efficient service.
- 7.4 IMPROVING THE ACCESS TO PRIVATE PSYCHIATRIC SERVICES. The barriers being the insurance funding itself, the incentive to keep consumers out of hospital, improving the selection and pay of psychiatrists working in the public system, the desire of private psychiatrists to contain their work load and also having the comfort of seeing the same patients for limited improvement in patient symptoms. Until the whole mental health system changes this will be challenging. With hospital outpatient appointments if every re-appointment was deferred for a longer period of 1-3 weeks, more room would be made to see acute cases. If consumers had access to an online emergency support system, as well as better protocols for ancillary non-medical exercises and strategies, then this should be possible .

8 EMERGENCY AND ACUTE INPATIENT SERVICES.

8.1 CRISIS AND EMERGENCY SERVICES: All consumers should have available emergency GP facilities preferably rather than waiting in an emergency department when their cognitive skills might not be suitable to mingle with other people and situations. GPs could as part of their ongoing accreditation be required to work as an emergency mental health therapist in public hospitals or emergency GP clinics. They would have more experience and it would save manpower. For known patients if good protocols were in place in that clinic then this should assist any unfamiliar GP. The hospital psychiatric registrar could be the backup. For crisis care, the relevant psychiatric hospital should have a service, and the trainee on call should be aware of any impending crisis and able to make the necessary decisions. All known mentally compromised patients should have a number to ring as should their carers. There should be a 'Crisis Hotline' to address all acute matters, especially pre-suicidal cases, and be able to also triage situations (e.g. police, ambulance)

8.2 ACUTE INPATIENT MENTAL HEALTH SERVICES: In major public health services the on call psychiatric registrar should be able to discern crisis call from others by a dedicated beeper or phone alert. This person should have a specialist on call availability as well. There should always be at least one available bed for transfer of an in-patient to a more appropriate psychiatric friendly ward to cater for acute mental illness in an in-patient (e.g. post-operatively) .

However in the case of other hospitals and institutions like aged care nursing homes where acute crises can arise post-surgery, or as complication of an event or therapy, the attending doctor or nursing staff should have a crisis number to contact. Possible the public hospital emergency service might be able to cope. The other possibility is that all private psychiatrists for ongoing accreditation could be part of an emergency roster where it is their own responsibility to register their dates of availability and to arrange for a replacement if they themselves become unavailable.

9. PHYSICAL AND SUBSTANCE USE COMORBIDITIES

9.1 PHYSICAL COMORBIDITIES: The first thing to establish is that the mental well-being of people with physical co-morbidities is considered at presentation. It is so intimately linked with best outcome that it should be considered to go 'hand and glove'. Just as chronic pain is linked with a variety of mental illnesses, so is the full range of physical challenges. It is not just the obvious difficulties with movement as after a stroke (cerebrovascular accident), or amputation, but should cover congenital and developmental anomalies. Disorders of speech (communication) and hearing also fall into this category. Of course burns needs to be placed in a category and physical disorders seems appropriate. Medical staff handling all these categories need to bear mental illness at all times, and in reality preventative steps taken where appropriate.

9.2 SUBSTANCE USE CO-MORBIDITIES. One cannot start a conversation re 'substance use' without looking at the mental well-being of children and young people. Prevention is so important in this area that again optimising parental guidance is

important. Any substance that has a direct effect on cognitive and other brain function has to be seriously considered for limiting its use in the community. Probably it is one of the single most important steps in prevention of mental illness and needs to be prioritised at the highest level. Next to the family situation the education system needs to prioritise this education as well. Similarly other medications need to be considered for their mind-altering effects. Pain medication (analgesia) is one medication that the consumer needs to understand the full story of its effects and side-effects.

9.3 WHAT MORE CAN BE DONE TO ADDRESS CO-MORBIDITIES. I have probably addressed this above but again it must be led from the top. The responsibility needs to be absorbed by everyone in the community. Everyone in their own way is a role model and an example to others. Of course medical personnel should be trained to consider comorbid mental health in all issues. However I again want to highlight the importance of establishing the best environment for mental well-being from conception. Parents must learn that this is the best gift that they can endow on their children.

10. TOWARDS INTEGRATED CARE: LINKING CONSUMERS AND SERVICES.

10.1 HELPING CONSUMERS FIND SERVICES. All medical clinics, pharmacies and hospitals should have and up to date online service directory. At the time of all presentations and discharges the appropriate service contacts should be printed off and given to the consumer and / or their carer. Each State Government should keep this directory on their web-site in a consumer (user) friendly format.

10.2 ENABLING COORDINATION AND CONTINUITY OF CARE. The most efficient way is to ensure that every communication is read within the working period that it is received and the responsibility is further absorbed by the mechanism of handover. The person delivering the message must make sure there has been a response by the end of their shift or then to delegate this responsibility. Where consumers have difficulty in being available to this process, the involvement of a carer or loved one should be established and documented.

10.3 ENABLING THE DELIVERY OF INTEGRATED CARE. If the above suggestions are not enough there must be an avenue for consumer feedback.

11. MENTAL HEALTH WORKFORCE.

11.1 WHY REFORM THE HEALTH WORKFORCE? Well basically many if not most health workers are doing a good job. However they are performing in the way they have been trained and under the rules that they have to adhere to, under the guidelines of their training body or government. However the NMHC inquiry 'Connections discussions' clearly shows that this is not what the consumers or carers or even health workers want. Secondly every part of the mental health system needs a review because we are not decreasing the amount of mental illness, in fact, in the most part, it is increasing, despite increased money allocated to it. Finally we have to be proactive in a rapidly changing world where

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information, technology, and other socio-economic and environmental changes are impacting significantly.

The mental health workforce needs to change because of all of the above. The Colleges of Psychiatry must critically review its teaching so that future psychiatrists can meet the challenges that consumers are facing and the changes they would like to see. The offices of the Chief Psychiatrist must also meet these challenges in a dynamic way and set themselves achievable targets. The Colleges of General Practitioners must also be prepared to prioritise mental health in the standards that they set for service and accreditation. The Nursing Federation and other nursing bodies must also ensure that what they have in place meets the new expectations of society. Similarly all other services dealing with the health needs of the consumer need to raise the level of their performance to ensure that full equality and human rights are achieved in delivering their services.

It should be emphasised that we all have to share in this responsibility and see that it is a necessary direction if we truly want to change the amount and level of mental ill-health in the community. We cannot expect consumers to develop more individual responsibility and resilience unless we are giving them the respect that all individuals deserve.

11.2 IMPROVING THE QUANTITY, MIX AND ALLOCATION OF SKILLS ACROSS THE HEALTH WORKFORCE. There is no reason why universities cannot within their courses allow for extra specialisation to ensure all skills are being met. If certain skills are avoided on selection then these are made compulsory units. Similarly all employment offices need to either make sure that they advertise the skills that they require, and also have the inherent skills to ensure that the candidates meet these criteria, or that they make the additional learning, part of the job acceptance. Candidate selection is important and ensuring that people are employed who have the necessary people skills, human rights attitudes, and workplace resilience necessary to ensure good treatment. Office managers and department heads also need to be selected with the above skills and be able to lead by example.

11.3 FOSTERING MORE SUPPORTIVE WORK ENVIRONMENTS. Technology can monitor workplace happiness and motivation and should be implemented. All employees need to be able to assert themselves within the framework of their employment, and feel that their work and ideas are respected and listened to. The onus is again on workplace supervisors to ensure this, and so on up the chain of responsibility and decision making. Friendships within the work environment should be encouraged to assist with workplace quality. At all times the importance of health care should be acknowledged so that all workers are completely satisfied with their allocated tasks.

11.4 ADDRESSING THE MISMATCH BETWEEN WHERE CONSUMERS AND THE HEALTH WORKFORCE ARE LOCATED. Most of my comments are contained within the above statements. However the biggest mismatch of service is in the areas of special need. Indigenous communities, immigrant communities, early childhood (from conception), workplace, comorbid illnesses, and importantly in the areas of the social determinants of health (housing, loneliness, food, safety, substance use,

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alcohol abuse, gambling, etc.) It should be emphasised however that even within these groups individual responsibility should be encouraged.

PART III—RE-ORIENTATING SERVICES AROUND CONSUMERS

12. PSYCHOSOCIAL SUPPORT

12.1 PROGRAMS AND SERVICES THAT SUPPORT RECOVERY. Again I must say that there needs to be a considerably up-scaled orientation to prevention. If every pregnant woman was given full psychosocial support from conception, and this was followed by full child and family support, then we would be well on the way to preventing mental illness, maximising well-being, and significantly decreasing future costs.

That having been said, recovery starts with the initial presentation. Maximising all the modalities to improve mental well-being should be offered with this first presentation, even though the consumer may not yet be ready to embrace them. Finally we must address the ability of consumers to cope after any mental health consultation or after hospital discharge.

12.2 THE DELIVERY OF PSYCHOSOCIAL SUPPORTS AND THE TRANSITION TO THE NDIS. Psychotherapy is in many ways preferable than the current medically driven system however there is nothing more frustrating to see services abused as much as they can be overused. There needs to be a better way of assessing the usefulness of a service to an individual taking into account their personality and skill levels. Again I stress there has to be responsibility shown everywhere where service providers are trained to assess needs and usefulness fully. Likewise all consumers and carers need to be taught how to make responsible decisions. **** CONCERN**** I do have a concern of cost blow-outs in the delivery of psychosocial supports just as we have seen it in the availability of psychological services from general practice where the initial 1-6 consults were always (nearly 100%) maximally used, and then requests for further 6 appointments requested (and usually granted by busy GPs). Criteria for useful reports back to GPs often not adhered to, and so there was poor evaluation of this service. Of course it can be argued all consumers could benefit from extra helpful talk, but one must ask 'How long is a piece of string?'

12.3 IMPROVING THE DELIVERY OF PSYCHOSOCIAL SUPPORTS IN THE NDIS. As soon as the consideration of 'Mental Health' gets entrenched in the learning and thinking of all health workers then this will follow. However as a cost-saving measure and to enable psychologists to be used appropriately, all staff must have appropriate psycho-social training. The most important skills within this are those of listening well and giving reassurance. It is important to maximise a consumer's confidence and optimism from the outset. Many of those in the NDIS framework are not only deserving of but would greatly benefit from psychosocial support.

12.4 IMPROVING THE DELIVERY OF PSYCHOSOCIAL SUPPORTS FOR PEOPLE NOT IN THE NDIS. Even more so the training of staff outside of the NDIS should be at a level where they can obviate the need of psychologists where possible. However there will be a need for psychologist referral just because of the current range of conditions needing support. However it should be envisaged that when the

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preventative strategies have fully taken hold this will dramatically reduce these needs. However this will take possibly at least a whole generation to occur other things being equal. That is why the reforms need to concentrate on prevention, on making mental well-being central to all policies and all institutions a fundamental goal. The whole community needs to address the need for better **respect** across the board, to increase their individual **responsibility** as they should with all major concerns like the environment and equality, and to develop a ability to adapt to a life set-back (**resilience**).

However over and above psychologists, there needs to be increased availability of other people to facilitate the solving of social needs, particularly the psycho-social determinants of health. Without delineating these in detail I emphasise that housing, food, unemployment, loneliness and alcohol and substance abuse should be the dominant services to increase delivery of support in. (One caution is that I am aware of is that services must be protected from the infiltration and abuse by people using that service for gain, and this has been noted in alcohol and drug rehabilitation areas. Some special need areas like indigenous people should be actively protected from any sort of abuse.)

13. CARERS AND FAMILIES

13.1 MENTAL HEALTH CARERS PROVIDE A VALUABLE CONTRIBUTION TO THE COMMUNITY. This is so true and of course required. Carers are the backbone of many areas but none more so than in mental health where their job can be very stressful and draining. Carers save an enormous amount of expense in providing assistance to those who are unwell. However as we have learned in the Aged Care system all health workers have to be selected and trained to meet the needs of those with problems, and we need to establish by use of technology and other feedback mechanisms that these workers continue to be happy in their job, to be motivated, and to be able to assert themselves (communicate effectively) with their superiors. In line with new societal attitudes to human rights expectations and equality they should receive the necessary training and reminders. As so often it is personnel from families that are involved, it should not be taken for granted that they will naturally be satisfactory, and support for them should be put in place.

13.2 INCOME SUPPORT PAYMENTS FOR CARERS. I do not think that all carers need support payments or indeed would want them, however they should be in place especially those who have to take time off work, or suffer financial loss in providing their service (as we have recently seen debated and provided in the bushfire crisis). Again there should be regulations in place to ensure there is no abuse especially in the current economic climate.

13.3 SOCIAL SERVICES FOR CARERS. I think that I have covered this sufficiently in 13.1 above.

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13.4 FAMILY FOCUSED AND CARER-INCLUSIVE PRACTICE. Again this comes back to evidence gathered by the recent NMHC inquiry. Family members and carers can suffer from sustained service to the loved one or consumer, and need support so that breakdowns do not occur, and the consumer is disadvantaged by no immediate service (Preventative action).

However family and other carers have a wealth of knowledge and insight which so often can effectively influence outcomes and make the entire support system more efficient. Thus systems must be in place to listen to the carers as well as the consumer.

14. INCOME AND EMPLOYMENT SUPPORT.

14.1 THE IMPORTANCE OF INCOME SUPPORT AND EMPLOYMENT SUPPORT FOR PEOPLE WITH MENTAL ILL-HEALTH. The facts that I would like to stress is that there are often situations which have led to ill-health or will aggravate recovery that are financially related. People with these illnesses often have a need for comforts, like smoking, which they need to purchase. Similarly there may be awareness of unpaid bills which will aggravate recovery. However there must be suitable social worker assistance in the supervision of income support. With employment support and consideration of mental well-being in all policies, and better workplace awareness of mental well-being, this will eventually follow through naturally. However Governments need to address the many benefits of these initiatives (not only the economic ones) in the workplace and establish guidelines for all workplaces (perhaps giving incentives perhaps for compliant workplaces).

14.2 CURRENT INCOME AND EMPLOYMENT SUPPORT PROGRAMS. Where they are in place it is good but there is often too much delay in getting these supports in place which has a direct effect on recovery and sometimes actually aggravates the illness. Otherwise as of above in 14.1.

14.3 IMPROVEMENTS TO THE EMPLOYMENT SYSTEM. The single biggest improvement would be Governments taking the initiative and ensuring all work places are equal, that human rights are addressed, that workplaces concentrate on establishing worker happiness and respect, and that everyone is on board during times of worker ill-health. The next important step might be one of measuring worker happiness and motivation by the use of simple technological apps or similar feedback mechanisms. However over and above these things is that all workers need to address their individual responsibility to their fellow workers by attending to their own mental well-being at all times and seeking help if needed.

14.4 TOWARD INDIVIDUAL PLACEMENT AND SUPPORT MODEL OF EMPLOYMENT SUPPORT.

I have nothing further to add at this stage.

14.5 INCOME SUPPORT BENEFITS AND INCENTIVES. The incentives must be directed both to the employer and the employee. The best incentive for both is to have a happy, vibrant workplace where all individuals are in optimum states of mental well-being. This is when work is more productive, all personnel are prepared to go the extra metre when necessary, and innovation and idea sharing is likely to peak.

Employers need to be educated to see the cost-economic benefits of not only such a workplace as described but there is cost-saving with early return to work. (Less training, less revision) Of course for the employee, the early return to a happy workplace definitely aids recovery through processes of usefulness, friendship, company, and distraction with something away from being pre-occupied with one's own dilemmas.

Having said this it would be ideal to legislate that INCOME SUPPORT BENEFITS are a condition of employment but then to protect against abuse by setting guidelines for recovery. Mental health workers, probably GPs should be trained to do this. However the GP practices then should also be monitored for consistency.

14.6 MUTUAL OBLIGATION REQUIREMENTS. I think that I have basically covered this above.

15. HOUSING AND HOMELESSNESS

15.1 HOUSING AND MENTAL HEALTH ARE CLOSELY LINKED. Every type of mental illness is well represented in association with homelessness. There are both international and national figures equating homelessness as one of the dominant psychosocial determinants of health generally, but even more so with mental health. Unless it is significantly fixed there will be almost totally inescapable, predominantly mental ill-health.

15.2 PREVENTING HOUSING ISSUES. It would be probably idealistic to consider but still realistically sanguine to argue, that if we could optimise the family environment, and prevent deleterious outside influences like alcohol and substance use, whilst young people are fully maturing and integrating into the community, then the need for emergency housing would be significantly lessened. It is just another reason for optimising the environment of pregnant women from conception and then the child from birth through to maturity. However the alerts for housing need should be addressed by direct enquiry whenever someone with a health issue, especially mental health issue presents.

15.3 SUPPORTING PEOPLE WITH HIGH NEEDS TO FIND AND MAINTAIN HOUSING. I feel that this is where one form of government help is required whether State or Local. People who are classified as high need, are usually where there is no family support, their illness is considered too intrusive or potentially risky for them to be placed in close contact with others, or where other circumstances has isolated them from the community (e.g. release from detention/prison). When the government delegates the responsibility to another service then it should ensure that the desirable outcomes are achieved. Consideration of increased use of unused buildings should be made, and rendering them suitable for habitat would create jobs, and provide suitable housing at low cost.

Again to obviate cost housing maintenance in each area could be offered to Service Clubs who often have multiple skills to complete this task and in particular, some, like Rotary, have a defined interest in supporting Mental Health. Otherwise Local Government should take this on board and accept some responsibility in doing so to optimise the security of their communities. Where possible the tenants should be gradually trained in this regard as it would aid their recovery and self-respect.

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- 15.4 RESPONDING TO HOMELESSNESS AMONG PEOPLE WITH MENTAL ILL-HEALTH. As alluded to earlier, every person who presents with a mental illness should be questioned re the satisfactory nature of their housing. Plans to acquire satisfactory housing for those who do not have this would be a significant step in ensuring their recovery.
- 15.5 PRIORITISING REFORMS. Certainly all efforts to prioritise housing should be made as it is closely linked to recovery, lessening of symptoms, improvement in alcohol and substance abuse, and less disruption of the lives of other citizens. Certainly it could be argued that it is unlikely that those who remain homeless will improve consistently from their symptoms or recover so that they can take an active part in the community.

16. JUSTICE.

16.1 THE INTERACTION BETWEEN THE JUSTICE AND MENTAL HEALTH SYSTEM. I feel that there should be dedicated medical officer's experience in mental health who can act as advisers to the justice system. The complexities of mental illness and therapy (Pharmaceuticals) necessitate good communication.

PART IV—EARLY INTERVENTION AND PREVENTION

17. INTERVENTIONS IN EARLY CHILDHOOD AND SCHOOL EDUCATION. This section is the most important step in influencing the amount of mental ill-health in the future. Some would argue that it influences every other part of our national and international policies. It is what will substantially dictate the future reduction in mental illness. If Governments are serious about reducing mental ill-health and replacing it with a populace of mentally vibrant people then this is the way to go.

17.1 MENTAL HEALTH AND WELLBEING IN THE FIRST 3 YEARS OF LIFE.

Some studies are now suggesting that even the pre-conceptual health of the mother is important in influencing the epigenetics of the mother and subsequently can influence the foetus and later well-being of the child. Certainly the mental well-being of the mother is important from conception. It is easy to understand that the whole maternal environment can influence her health and therefore influence the foetus through neuro-chemical pathways. Once the child is born obviously its health will be influenced by the environment in which it is placed. I believe that looking after the mother from conception and doing everything to ensure the family environment is optimum will go a long way the substantially reducing mental ill-health in the future.

17.2 MENTAL HEALTH AND WELLBEING FOR PRE-SCHOOL CHILDREN. I

suppose this classification allows for children who start to be placed in the company and under the influence of other carers and instructors. However in many ways its importance is no different to 17.1. It is a prime time for the mental well-being of preschool children to be influenced and for

healthy behaviours and reactions to be cemented in. However the responsibility of parents should remain at the highest level and consistency in a loving support maintained at the highest level. Parents must realise that there is no more important task that they will ever have than to raise a child well. However pre-school carers like all teachers in the future should also realise the importance of their role. Teaching, instructing and setting behavioural guidelines by being consistent role models is an extremely important influence on the mental well-being of children.

17.3 SUPPORTING CHILDREN AND YOUNG PEOPLE DURING THEIR SCHOOL YEARS.

As with 17.2 until we can ensure every child has been nurtured optimally from the time of conception, (and this might take 30-40 years), we need to optimally nurture their mental well-being from the time of school presentation.

Every teacher and school should, in reality, prioritise this before academic standards are set. Attention to an additional 3 'R's' need to be considered (as they should right through society), **RESPECT, RESPONSIBILITY AND RESILIENCE**. The lowering of these three attitudes in society has had a direct cost-economic effect on so many of our present outcomes. No government can expect to have a bottomless pit of resources and all of our Australian society needs to show more respect (less anger, violence etc.), to adopt more personal responsibility (driving cars, adhering to guidance of rules), and more resilience (ability to pick ourselves up after minor setbacks). The education system is the ideal place for all children to learn this, to debate its benefits and add to, the importance of this. Just like it should be driven from the top of government where standards of living and role playing are so important in influencing the mind-sets of children, it should also be driven by the principles in schools where it is also important to have consistent policies and goals. However as in other areas of health we must ensure **quality and human rights** are observed at all times and for children to see that they have a voice through their peers. Thus peer engagement in this process of enhancing 'respect, responsibility and resilience' is extremely important in maximising the upskilling of other children.

17.4 THE WELL-BEING AND MENTAL HEALTH WORKFORCE WITHIN

SCHOOLS. There will be need to address the immediate provision of an appropriately trained mental health worker within school environments until we can ensure through the teacher training programs that sufficient teachers can be trained to specialise in this role. It is better that this course is adopted in my belief as mental-wellbeing trained teachers would maximise the usefulness of staff in schools. It also allows students whose mental health concerns fall outside of the teacher capabilities to be directed efficiently to the best area for further evaluation. (The same would need to occur if a mental health nurse or other worker was allocated to the school.) At all times, as with all areas of mental health evaluation, protocols

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should be established to ensure no abuses can arise (as in the provision of unwanted substances).

17.5 ARE WE ON THE RIGHT TRACK? ASSESSING THE EFFECT OF POLICY ON THE WELL-BEING OF SCHOOL-AGED CHILDREN. Well yes and no, and of course! The right track is addressing issues from conception. Using every service possible to support the mother from conception and also ensuring consistency in her environment right through to school entry. If we wait until school entry then that child may have been influenced by all manner of psycho-social influences with alcohol and substance abuse, violence, neglect, loneliness, and physical symptoms either directly or indirectly. However it is then important to have available mental health interventions as soon as possible in the pre-school and school places.

17.6 QUANTIFYING THE BENEFITS OF RECOMMENDED REFORMS. If one can quantify the effect of poor home environments in early childhood (under 3) establishing the fore-runners of mental health issues like anxiety, depression, personality disorders, domestic violence, anger, and the likelihood of later substance abuse we can already see an established association between ill-health and poor mental well-being environments. Then add to this the effect of children exposed to neglect, loneliness, poor respect, poor parental responsibility, bullying, violence, and alcohol and drug abuse we see an escalation in mental ill health. Again the same associations follow through to the full maturity of the individual. It is undoubtedly the best that we can do to obviate the growing mental health problems in this country, but everyone must be on board, from the Prime Minister, every Federal and State Minister, through to every part of our society. There are extremely substantial benefits to our country. The cost-economics are not just in the Health Budget but will be seen in every part of our workforce and community life. It will with time influence most issues like road toll, suicide, time off work, bushfires etc., that have significant direct costs, but also enhance to general optimism and skill levels and motivation.

18. YOUTH ECONOMIC PARTICIPATION

18.1 YOUTH MENTAL HEALTH AND ECONOMIC PARTICIPATION. Basically if we are optimising the mental well-being of individuals then they will look after themselves better. This means that there will be less time lost in the workforce and education. Maximising the education means then that there will be more consistency in idea transformation and that innovation will be greatly enhanced. Universities and other tertiary institutions must be receptive to this process.

If young people are in the best state of mind and they are engaged with receptive work-places then this will also encourage better workplace idea

transformation and benefit the workplaces considerably. More workplaces will recognise the benefits of this association.

- 18.2 SUPPORTING YOUTH IN TERTIARY EDUCATION. Of course the brains of many students are still maturing and being exposed to other influences. Student's mental well-being needs to be monitored and I would think that the less intrusive, time saving measure, would be an I-phone app which monitors their well-being and can give alerts. Institutions should provide a service and Heads of Departments should also prioritise this as it would enhance respect and loyalty. However as well as focussing on supports when a student is suffering we should encourage individual responsibility.

However it is important nevertheless to cater for the full range of situations facing students in their personal identity, human rights needs and societal equality needs, as well as any other significant life situation that intrudes on their ability to study to the best of their ability.

- 18.3 SUPPORT FOR YOUTH TO RE-ENGAGE WITH EDUCATION AND TRAINING. Of course if the circumstances are advanced to a situation, or were of such a nature that a student needed to have time away from their studies, then the more support that they can get the better, as it would significantly lessen the impact on both their own studies, and the course, (e.g. where other students have a reliance on their contribution). However as with all areas it is optimal to try and prevent these advanced situations by early intervention and also encouraging students to have the responsibility to seek help earlier. The support needs to be in whatever form is appropriate to the situation. A phone app may be immensely suitable in this situation to guide the need for additional support.

19. MENTALLY HEALTHY WORKPLACES

- 19.1 MENTALLY HEALTHY WORKPLACES. This has been alluded to above. All workplaces must understand the cost-economics of having healthy workplaces. The costs associated with absenteeism, pre-absenteeism, post-absenteeism, loss of continuity, training other people, recruiting other people, and loss of good communication and innovation are all significant. Having a healthy, friendly, supportive workplace has shown to enhance proficiency, efficiency and loyalty, as well as less time off work. There is also the factor that such places are today considered important for optimising human rights and equality issues. Again the factors of respect, responsibility and resilience are in play. It would be a consideration that all

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employees and staff are monitored by a phone app which monitors their state of well-being.

19.2 **WORKPLACE HEALTH AND SAFETY AND WORKPLACE MENTAL HEALTH.** The well-being and mental health are closely associated with workplace safety as well as mental health issues like depression and suicide. Suicide in the workforce is still a very large consideration of which the full extent is difficult to evaluate. Also the workplace is very open to other influences from crime, to substance abuse, bullying and isolation. A dynamic workplace monitors these things as well as taking proactive measures to educate employees.

19.3 **WORKERS COMPENSATION ARRANGEMENTS AND WORKPLACE MENTAL HEALTH.** Again whilst it is important at all times to encourage individual responsibility for health and mental well-being, it is important for all workers to know that they will be fully supported at times of injury or illness.

Good understanding and compliance with these arrangements greatly improves the recovery and lessens time off work. It is no better way than the employee hearing this from the top (boss).

19.4 **EMPLOYER INITIATIVES TO CREATE MENTALLY HEALTHY WORKPLACES.** As mentioned earlier the usefulness of phone apps to monitor well-being and conveying from the workplace a message of concern that everyone is feeling well is possibly useful as alerts can be registered early, and action initiated. Having a person delegated to enquiring early when someone is absent also helps in getting the situation appropriately assessed with better outcomes, as well as enhancing good well-being everywhere. Having opportunities for employee feedback and vocalising either concerns or ideas also enhances confidence in the workplace and loyalty.

19.5 **THE RETURNS FROM INVESTING IN WORKPLACE INITIATIVES.** The cost-economic benefits as well as loyalty factors have been discussed above.

19.6 **IMPROVING EMPLOYER INTERVENTIONS.** Both State and Local Governments should take this on for both employment and economic reasons. No area benefits if a business folds and local economies can suffer. Incentives should be given for all workplaces that can be shown to have introduced initiatives like phone apps and all businesses that have been shown to reduce both their accident and mental illness rates, as well as employee time off perhaps.

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20 SOCIAL PARTICIPATION AND INCLUSION.

20.1 BARRIERS TO SOCIAL PARTICIPATION AND INCLUSION. Again if there is a focus on optimising mental well-being from conception and throughout the educational process, and optimum mental health workplaces are encouraged, then eventually this problem of social isolation and loneliness, and its inherent relationship to mental ill-health should be minimised. An understanding of the need for basic human rights and of equality is extremely important and should be taught right from birth. An understanding of all the factors of the psycho-social determinants of health should also be understood so that everyone can share in the responsibility of minimising these in our communities.

Basically the biggest barrier to social participation and inclusion is our motivation and desire to involve as many people as possible. It is a factor which perpetuates the stigma associated with mental ill-health, and it is a responsibility that we must all share, without casting that responsibility onto someone else. Of course other barriers are the need to ensure that others are safe and not threatened by the circumstances themselves, and the nature of the mental health issue facing the consumer. Depression and often alcohol and substance often isolate individuals, as do chronic mental health problems like bipolar, personality disorders and schizophrenia.

20.2 PROMOTING SOCIAL PARTICIPATION AND INCLUSION. The earlier that health workers and other carers can intercede the better the outcomes will be. Social Isolation needs to be addressed like accommodation with every mental health presentation. This is why eventually devices like phone apps will be useful in monitoring behaviour, and alerting circumstances when social isolation is apparent. However all people should be aware of a behaviour change and where an individual's behaviour significantly changes, particularly with regard to an expected social participation, then they should be encouraged to take action. Similarly failed appointments within the mental health system should be monitored and prioritised for action. All individuals should know that sharing their concerns with others is a positive way to improve their mental health in the same way other actions like exercise improves our well-being.

20.3 IMPROVING THE SOCIAL PARTICIPATION FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE. The most significant thing would be for them to see that the whole country accepts their position as first nation people, and recognises their rights and culture fully. The full implications of the 'Uluru Statement' should be put in place. I believe that only then will we go forward as a country. The next important thing would be to recognise their full human rights and ensure that no other people are undermining this by any form of abuse (e.g. alcohol or substance abuse). The next thing would be to maximally respect their elders everywhere and involve them with setting the goals for maximum social participation (We see good examples in sport). Finally we should consult them where possible for advice in handling this and other problems facing this country.

20 SUICIDE PREVENTION

20.4 SUICIDE REMAINS A SIGNIFICANT ISSUE IN AUSTRALIA. Again the most significant step is to focus on the optimum mental well-being from a mother's conception and then following this through the educational process. Despite all the money allocated to addressing suicide and all the institutions offering help to people who are pre-suicidal we have not made worthwhile steps in reducing suicide frequency. I feel this is because we have not addressed preventative measures sufficiently and stressed the importance of quality family structure. All of us again have a responsibility for not only our own mental health but for others.

We must address the dominant areas like social media, the workplace and the driving responsibility. Alerts must be in place in all circumstances where there is perceived individual loss or hopelessness like job loss, relationship breakdown, and loss of loved one, including pet, financial loss or perceived catastrophic event like a war, vehicle crash or bushfire.

20.5 THE COST OF SUICIDE IS HIGH. Of course there is the personal cost to individual and all people associated with that person, but there are all the additional costs to those health workers involved like police, ambulance, and health staff. Depending on the modus operandi there may be the additional costs with forensic investigation, other personal involvement (e.g. train drivers), and necessary investigations in the workplace etc. Then there is the loss of a trained employee and retraining of a replacement, as well costs of disruption of service.

20.6 WHAT WORKS IN SUICIDE PREVENTION. Significantly optimising the mental well-being from birth right through all the years to full maturity clearly minimizes the risk. Establishing consistent personal happiness is important in prevention. Early recognition of a change of mood, behaviour, isolation, and increased attendance at a health clinic and then going beyond RUOK. If someone recognises concerning symptoms then that person should feel obliged to follow this up until complete recovery is assured. Attention to warning signs like any job loss, financial difficulty, domestic dispute or other major insult as well as a new significant life threatening illness helps with early recognition of situations where suicide can be contemplated. Of course, especially in young, immature people, the suicidal occurrence in a friend or known personality (e.g. media) can invoke copycat suicidal tendencies, and should cause alerts.

- 20.7 EMPOWERING ABORIGINAL AND TOREES STRAIT PEOPLE TO PREVENT SUICIDE. Entrusting elders with the responsibility to guide their youth through the transition towards western living and opportunities in the rest of the world, and educating the youth that alcohol and substances are not the answer to integration problems. Using and paying significant aboriginal identities like sportspeople to guide their young people.
- 20.8 IMPROVING OUR APPROACH TO SUICIDE PREVENTION. Governments must see the importance of establishing role model behaviour and attending transparently to important issues that worry people like climate change, wars. Establishing the importance of mental health in all parts of our community and establishing the importance of good mental well-being from birth. Improving family responsibility to good well-being in the home environment throughout life and of schools addressing mental well-being as part of the curriculum. Ensuring that people do not stop at RUOK and follow through any alerts until health is assured.

PART V--PULLING THE REFORMS TOGETHER

21 GOVERNANCE

- 21.4 CURRENT GOVERNANCE ARRANGEMENTS
- 21.5 CODIFYING FEDERAL RESPONSIBILITIES
- 21.6 STRENGTHENING THE NATIONAL MENTAL HEALTH STRATEGY. The biggest problem that I see is that there are no defined time/outcome objectives which are necessary to adhere to. Definite achievable goals are not set, monitored, evaluated, and acted upon. There may be not enough ownership and too much delegation of the responsibilities in this process. The next important step is that it should be led from the top, the Prime Minister, through all government departments and it should be adopted as a strategy of **bipartisan** importance. It is very well all right to establish a 2030 plan as long as there **achievable goals** for every year. It is too easy later to say that the plan is not working and re-write the plan, again deferring useful change.
- 21.7 ENHANCING CONSUMER AND CARER COLLABORATION. The recent NMHC 'conversations' project clearly defines what consumers and carers want. I do not think there will be a problem in getting their collaboration if the plan is led from the top. The barriers will be in getting the government to convince the 'establishment' that this is the direction that it wants to follow.

21.8 IMPROVING ACCOUNTABILITY. Ensuring that all parties are led from the top. This reform is of National importance and should be driven by the Prime Minister and all politicians in a bipartisan show of allegiance. Mental well-being affects all of us both personally and by association with all others with whom we work. It is the cement that will bind us as a country and possibly could move us as a nation into the next zone as we maximise our strengths with mental health being one of them. The cost-economics of mental health are one financial burden that we need to nail simply because by doing so it launches us as a country into an atmosphere of world advantage.

In most of the initiatives I have examined, established good, reliable feedback mechanisms, and good communication is the goal in achieving the best accountability. It must become ingrained in all of us to do this again from the top down. It improves transparency, gives good alerts, maintains good mental well-being at all levels and allows the supervisors of departments everywhere to see the accountability then falls on their shoulders.

21.9 BUILDING AN EVALUATION CULTURE THROUGH THE NMHC. I agree whole heartedly that the NMHC should monitor the goalposts and be able to judge unsatisfactory results and failed scoring. Looking at the history of government plans at both State and Federal levels there is significant lack of initiative in ensuring goals are actually achieved within a **reasonable time frame**. So often long periods are set for a plan, then there are reviews, and other delays whilst further information is sought. The NMHC must be able to assert itself to ensure that the reforms are led from the top, that feedback from the medical and nursing colleges is obtained within the proposed time frames, and that the other reformative changes are being absorbed and activated in the community. (This is a topic that I would be happy to discuss in more detail and help with).

22 FEDERAL ROLES AND RESPONSIBILITIES

22.4 STRUCTURAL FLAWS IN MENTAL HEALTH. There are several flaws but the most important is that the mental health system has been driven by a medically reliant (big pharmaceutical influenced) system. This needs to be replaced by a social system that needs to be driven by a consumer (lived experience) and carer orientated system that is totally in tune with the current international and national expectations with respect to equality and human rights. From the current system the flaws flow down by osmosis to the substructures. Thus the colleges of psychiatry, chief psychiatrist offices, colleges of general practitioners and the nursing

federation have all had a focus which has followed the medically driven system, and have not in essence attacked the underlying problem of why we have mental health problems and what can be done to reduce this burden.

22.5 IMPACTS OF RECENT REFORMS. In reality of course any initiative in mental health sounds good, reassures some, does achieve some good, and is of course good. However we are not impacting mental health in reality. As in previous discussion we need a total reformation with the focus on a consumer driven prevention system, knowing that the current treatment side of mental issues will exist side by side, and still needs to coexist with changes to its structure.

22.6 THE DESIRABLE DESIGN FEATURES THAT WE WANT. (A) That everyone is on board. That the whole country to a person recognises the value of good mental health. This must be driven from the top. (B) That we are optimising the mental well-being of all children from birth by starting with the mental wellbeing of the mother from conception and eventually from pre-conception. (C) That we, where at all possible, do everything to strengthen the importance of family bonding and persisting family adhesiveness. (D) That we prioritise the importance of wellbeing in schools by instituting into the curriculum its importance in life skills and learning, and ensuring that it is led from the top, both in education departments as well as school principals. (E) That all citizens know that mental wellbeing is a responsibility of all individuals but that all citizens also share in the responsibility of ensuring our fellow man is well. Thus we extend the current focus on recognising pre-suicidal warning signs or alerts to increased care of our fellow man. (F) That the design enhances the need for increasing our mutual respect, our individual responsibility in all things, and our resilience in overcoming setbacks. No government can afford a fully reliant populace. (G) That the entire medical system is focussed on a consumer/carer oriented mental health system where consumers full human rights are recognised with the full range of possible therapies offered. (H) That we set in place a humane system so that when the mental illness of a person dictates that they cannot actively decide the best course of action for themselves, then we have an alternative system that places that person in a position where they will not suffer more or be a danger to themselves or others. (I) The system needs to prioritise the psychosocial determinants of health so that we can dramatically reduce homelessness, loneliness, alcohol and substance dependency, and enhance individual usefulness and outcomes. (J) That we have a constant review occurring with an annual presentation of the results achieved and targets that have not been met. (NMHC) This might mean that the NMHC needs to be substantially has to be up scaled.

- 22.7 CHANGES TO THE ROLES AND RESPONSIBILITIES FOR PSYCHOSOCIAL AND CARER SUPPORTS OUTSIDE OF THE NDIS. Absolutely there needs to be a significant change on to a system that enhances personal responsibility and a full focus on achievable goals. Hopefully with attention given to prevention and better well-being throughout life then gradually the need for psychosocial support will be lessened with time. However in the short term there must be a stricter governance on the amount of psychosocial support given and a shift of responsibility onto the psychologist of determining the priorities for the best outcome. Nevertheless increased attention needs to be given to the psychosocial determinants of health and increased social worker support will need to occur in the short term. **Carers are the backbone** of mental health and therefore this must be recognised by having a system that listens to them and learns from their wealth of experience, and that proactively helps them to maintain their own health and well-being.
- 22.8 TWO OPTIONS FOR REFORMING MENTAL HEALTH SYSTEM ARCHITECTURE. There in reality is only one option. History has shown that we have been superficially renovating (trying to repair, improve) the mental health system for eternity (almost since it was established). What is needed is a combination of a total rebuild but also some renovation to allow continuity in treatment of mental health issues as they occur until the full reforms can take effect (noting that this will likely take a generation and a half) if reforms are instituted soon.
- 22.9 AND 23.7 SEE 23.3 ABOVE

23 FUNDING ARRANGEMENTS

- 23.4 PRIMARY MENTAL HEALTH CARE FUNDING I feel that the Government needs to initially provide extra funding to the equivalent to what it is estimated that the amount that mental health issues are costing the country. It is an emergency. It needs to be fixed. Once fixed there will be enormous benefits to the entire country. All government departments need to service this increase spending.
- PSYCHOLOGICAL SERVICES. This needs to be tightened immediately otherwise there will be blowouts particularly in relationship to the NDIS.
- SOCIAL SERVICES. There needs to be increased funding allocated to solving the psychosocial determinants of health.
- PHARMACEUTICALS. With time there will be considerable savings in the need for pharmaceuticals as more and more people focus on mental well-being, and opt for non-drug therapies to help their lives.

25 A FRAMEWORK FOR MONITORING, EVALUATION AND RESEARCH.

Data collection and use, monitoring and reporting, evaluation and research is all extremely important and the government should direct some of its research grants into this area. I feel that the NMHC should be in control of this because the reform of mental health is fundamental to the country and must be prioritised to the level of 'National Security'.

26. BENEFITS OF REFORM

26.1 ESTIMATING THE HEALTH AND ECONOMIC BENEFITS OF REFORMS. I hope that my various presentations have made clear what I feel are the health and economic benefits of the reforms. In summary however this is how I visualise the benefits:

- (a) Less peri-partum and post-partum mental health issues.
- (b) Less domestic violence and better family unity and mental well-being.
- (c) Better pre-school child mental well-being.
- (d) Better school education outcomes, better life skills, and community participation.
- (e) Less alcohol and substance abuse with its associated problems.
- (f) Less road trauma because of attitude change and more responsibility.
- (g) Better academic and workplace goals and achievements.
- (h) Better workplace environment with less time off work, less injuries and suicide.
- (i) Less suicide risk with better suicide outcomes generally.
- (j) Better recovery with less time in hospitals with mental health issues.
- (k) Better outcomes in marginalised communities.
- (l) Better general community respect through better human rights observations.

In general the benefits should be shown in every part of Australian life and participation. There should not be one area of life where the reforms will not impact eventually.

APPENDIX

A. SUMMARY OF NEW DIRECTIONS FOR MENTAL HEALTH SUBMISSION

- 1.** There needs to be a much wider understanding of what good mental health and well-being is, in the community for all of life, and how this can reduce the burden of mental illness significantly.
- 2.** There needs to be better health literacy within the political arena, the workplace, and places of education.
- 3.** There has to be a total acceptance of the enormous cost-economic analysis of mental illness and just how significant the benefits of correcting the anomalies are.

4. Governments must consider, not only for reasons of human rights and equalising opportunity, seek to get its advice equally, not only from the peers of learning, but also from the experience and insight of consumers, carers and workers in the field.
5. There needs to be a changed model of mental health care away from the diagnosis, symptom driven medical model to one of maximising mental health and well-being.
6. There has to be a re-modelling of medical illness appointments to allow people at all ends of the symptom presentation range to be triaged and treated accordingly.
7. There has to be not only in all medical practices a consideration of mental well-being in all consultations and public encounters.
8. There has to be more services provided to meet the needs of recovery after discharge from acute services to prevent re-admission.
9. There has to be an urgent study of why the levels of respect, responsibility and resilience have fallen away in society and the effect on mental well-being.
10. There has to be an urgent provision the optimal pre-conception, post-conception, pregnancy, post-partum, and early family life-style environments.
11. There needs to be the introduction into all political decision making, the benefits of good mental health strategies to meet community needs.
12. There needs to be significant mental health and well-being strategies employed into all work-place, educational, sporting and recreational institutions to optimise outcomes.
13. There needs to be urgent re-assessment of strategies to handle major determinants of mental illness like early child well-being, drug and alcohol abuse, loneliness, homelessness, social media, societal role-models (from politicians down), indigenous segregation, and immigrant well-being.
14. There needs to be an absorption by the community at all levels of the need for personal responsibility as no government can hope to address the current needs of a rapidly changing society.
15. Finally there needs to be more monies allocated into research into all these areas of important need and better outcomes for Australia.

B. REASONS FOR ATTENDING THE ADELAIDE PUBLIC HEARING

Starting with Key points:

What we need is not a “Generational Shift”, but a ‘dynamic total change’ because what we have had for many generations is a mental health system that is not working, and a regression or perversion in the ability of people to deal with a rapidly evolving world. What we have had is a system which has allowed 20% of its people to suffer a mental illness in any one year, 2-3% of them to suffer a serious, life altering, handicapping illness, with another

15% suffering an illness which significantly alters their enjoyment of living, has seen a growing suicide rate despite significant money being allocated to areas where suicide ideology is advanced, and has resulted in an enormous economic burden to the country and its citizens.

The system that we have currently in place whilst serviced by many industrious, worthwhile people and efforts, has not reacted to this deteriorating compromised situation as it has been fully attending to what has been seen as major mental health issues in the manner in which their medical training has evolved. The underlying medical psychiatric system has not significantly changed in many decades apart from some socio-economic initiatives in repositioning consumers with chronic mental health illnesses more into the community, some general community education in an attempt to reduce the stigma of mental illness, some improvement in medication and therapy regimes, and increased attention to the personal and community awareness of suicide and its presentations. Emphatically little has been done to prevent the incidence of mental illness or to keep the focus on mental well-being in a systematic, formative and decisive way.

Accordingly mental ill-health has increased, suicide rates haven't changed and possibly increased, the economic cost to the workplace and individual increased, and there seems to be little improvement in the ability of governments to react effectively. Our citizens as a whole seem less able to cope with the pressures of daily living, the changes that are portrayed by an ever increasing intrusion of media and social media, and by the ambiguity they see almost daily demonstrated by world leaders and other influential individuals with the result being a decrease in their general respect for people and entities, a decrease in their individual responsibility and a decrease in their resilience or ability to bounce back from adversity. Of course there has been some recognition of these issues, and plans discussed and even established but little in the way of ensuring that these plans are perpetrated and actualised. Governments seem to be happy to allow plans to be invariably reviewed in 'perpetuum et unum diem', often resulting in subsequent delays, recycled plans and risked being pushed aside.

Many think that the problem is enhanced because we have this dated medico-pharmaceutical model of care for mental illness. There is no doubt that this is so. Psychiatry has been significantly influenced by the pharmaceutical industry where the emphasis has been on regular prescription of expensive drugs, in big doses, with no attention to individualisation of effects and consumers human rights. There has been consumer and carer concern over the influence of the pharmaceutical industry to individual psychiatric decision makers by direct support for their interests, programs and needs, whether fraudulent or not. The National Mental Health Commissions recent excellent Australian 'Connections-National conversation Program' has clearly shown the views of consumers, carers, and mental health workers, and emphatically demonstrates also the need for dynamic change. The message was consistent and clear that the current system is not working.

OPPORTUNITY

I personally feel following the Productivity Commission Draft Report, The National Mental Health Commission 'Connections conversation' program, various state mental Health reviews, various international cost-economic reviews of cost of mental illness, the World Health releases on Mental Health, that there is no better time for a complete change, a dynamic reconstructive transformation and metamorphosis of the way we look at our way of preventing and treat mental illness. With a significant part of the populace confident such an opportunity is golden for a dynamic change which place the focus on prevention and therefore significantly reduce the suffering of the Australian people as well as significantly reduce the current economic and personal burden of mental illness, then I feel the Productivity Commission has a golden opportunity to respond to the challenge of leading this Country, if not the world, forward. The difficult part is not this decision but planning the strategy of implementation so that the plan is achievable, monitored and then followed through to full execution. The Government, Productivity Commission and National Mental Health Commission need to take ownership of this opportunity which could be the most far-reaching, influential, note-worthy and world-changing transformation to effect major positive change in mental health ever seen.

SUMMARY OF SPECIFIC KEY POINTS IN THE PRODUCTIVITY COMMISSION DRAFT.

FOCUS: The report seems to have been written with a clear emphasis on distinguishing between those who are unwell and those who are not (A 'THEM AND US' format). I feel that mental well-being is something that everyone should aspire to and that there is a continuum, as it were, with various degrees of un-wellness. If this could be expanded conceptually then we would be a long way on the path to resolving stigma issues.

CURRENT DESIGN is around a medically designed system which radiates out from how psychiatrists and general practitioners are trained. It focusses on symptoms and treatment. In so doing it frequently fails in its designated task, fails to recognise an individual's dignity and other basic human rights, fails to modify its therapy to the consumer's individuality and specifically fails often to address other social determinants, and physical illnesses.

IMPORTANCE OF CHILDHOOD: The draft correctly identifies mental illness as often starting often in the young but should in reality make more of the need for good mental well-being in all concerned from conception (noting that some studies are even showing pre-conception environment is important).

LITERACY: Again the draft focuses on mental illness and not on continuum from good mental well-being into the variations of poor mental health. Is it possible that this reflects the level of understanding (literacy) in the community of what is good mental well-being is and what can cause mental illness? Improvement in mental health literacy and awareness from the top echelons of government to all areas of community life would significantly improves dilemmas in persisting stigma and encourage earlier presentation. (Examples of benefit in this area have been seen in sport, music, and various artistic fields.)

PSYCHO-SOCIAL DETERMINANTS OF HEALTH: There is a real need to look at psycho-social determinants of health seriously and upscale actions needed. One cannot emphasise enough the importance of the basic necessities of living in food, sleep, housing, and protection. One cannot effectively treat, rehabilitate or enable recovery without attention to these at diagnosis. However the importance of vigorously tackling the issues of substance abuse and technological influence should not be under-emphasised.

POLITICS: There needs to be an urgent acceptance of mental well-being in all policies and in all situations. The noted considerable decrease in individual respectfulness, the ability to accept personal responsibility for life and actions, and of personal resilience to expected and predictable setbacks, has influenced the community response to life itself, needs to be addressed. The Governments (politicians) of the day need to lead the way in showing respect, responsibility and resilience so that this role-playing can gradually influence the community's commitment doing everything daily to keep themselves mentally well.

COST-ECONOMICS: I think there is widespread agreement with the estimation of importance of cost-economics of mental ill-health in the workplace. However I am not sure if the influence of poor mental health has been considered on every single part of life, from domestic well-being, post-partum life, family environment, education, workplace, recreation, physical illness, post-retirement, aging, terminal illness, as well as in the dominant daily issues including road toll, violence, crime and substance abuse. Similarly I am not sure whether there has been adequate analysis of the benefits of everyone being totally mentally well (i.e. fully on their game!)

COMMENTS ON REFORM AREAS

Reform area 1: prevention and early intervention for mental illness and suicide attempts.

Priority should be given to optimising well-being from conception and throughout formative stages of child's development. (If every child can be ideally raised to believe that they are OK, and that they are loved then this would significantly help). I would like to speak to this in more detail if the opportunity arises.

Need to go further than RUOK (Are you OK). If something triggered question then this is sufficient cause to suggest follow-up until good mental well-being is established. There is also much to be said here.

Reform area 2: close critical gaps in healthcare services

There would be nothing better than having a registered experienced medical officer on call in a hospital with the psychiatric registrar there for extra assistance. It could be a part of the necessary continuing education and accreditation process.

Reform area 3: investment in services beyond health

A significant upscaling of not only accommodation (housing) but all the social-determinants of health.

Reform area 4: assistance for people with mental illness to get into work and enable early treatment of work-related mental illness

Technology should assist in the reporting of the state of mental well-being on arrival and again at the departure from the workplace. Apps for phone are in the process of development.

The responsibility should be changed away from workplace in reality to an individual to keep self well, although the workplace has to consider the safety of others.

Reform area 5: fundamental reform to care coordination, governance and funding arrangements.

Absolutely agree that NMHC needs to be given statutory agreement to control this new direction of mental health away from medical model onto a well-being through life model, whilst allowing equality, diversity, full human rights.

OVERVIEW:

At the Productivity Commission hearing I would be prepared to comment on all parts of

1. The Case for Major Reform.
2. Re-orienting health services to consumers.
3. Re-orienting surrounding Services to consumers.
4. Early Intervention and prevention.
5. Pulling the reforms together.

Sincerely

Dr Bob Riessen. MB.BS.