Productivity Commission – Mental Health

Political economy becomes manifest when Commonwealth and States share legislation and policy here the Commonwealth is the prime funding source and the states the service provision and improvement source. Both adopt the Population Health approach and can accommodate the contemporary recovery mental health practices and standards.

A range of health issues arise and are inclusive of public policy, supported environments, facilitation and strength, community action and participation, equity and health status and meet Declarations forged in Ottawa and Jackarta. Each is fundamental to everyday nursing and social work.

Two models emerge and overlap namely the medical and recovery model. The first is diagnostic, classified (ICD10, DSM IV) and assumes clinical recovery as measured by freedom from disease and absence of illness. Here Relapse and incidence of admissions become markers of measurement. Recovery is more than illness and treatment.

Recovery -Clinical and/personal.

Recovery qualitatively benchmarks the challenge of going beyond illness and treatment, considers tidal flows and pioneers hope. Deegan (1996 and subsequently) advocates an environment of hope with all other environments negotiatged. Recovery can balance and redress fear, powerlessness and lack of help. As a vehicle it offers opportunities for potential, capacity and empowerment and this assists growth, respect and worth of the individuall. Systems approaches aggregate here through inter-relationships between and across space and time.

Adding value we can embrace CBT for negative self-talk, take 360 degree views and consider SDH and SDHI considerations.

Recovery views on mental health are a continuum of clinical and personal considerations. The mental health continuum offers mental illness (negatives, disease and illness) rising to mental health (everyday, positive and strong control within our community).

Social work

The AASW values of individual worth,, self-determination and empowerment offer: 1. The person in their environment,
   2. Being beyond illness and treatment and 3. Consideration of broader human, social and political issues. Community life here sees culture, institutions, legal frameworks,political systems, socio-economic

infrastructure and inter-personal relations as significant and important. Moreover these are created and create social reality

Optimal thinking : We can even across current silos contribute to clinical and personal recovery by fully applying optimal team philosophies drawn in a productive, creative and helpful msnner redressing shortages and gaps around particular clients (the minorities). Purpose and policy can be whole of life and tidal in consideration. Why should we stay static and discipline bound.

Peer workers as experts of the lived experience need to be in the discipline mix.

Structural weaknesses – We can recognise the limitations of psychiatry and psychologists a political movement of power and control and enhance the mix of approaches. Extending the principles of Recovery across the five national mental health plans allows us to create spaces for mutual support and capacity building , enhancing individual worth
and social mobility towards community life.

Better communication between PHNs, GPS and the tertiary sector assist. Independent rights advocates heping consumers and carers is a large positive.

Specific Health Concerns:

Suicide Prevention may be a first contact where we can check a person's safety, communicates s caring and helpful approach and build rapport. Recognition of deep distress and trauma need to addressed.

Achieving better outcomes also is the multi-entry stepped care appr and greater awareness and appreciation of what mental illness and health actually is.

Negative Vibes: The arrival of a mentally ill person in marked police car and handcuffs raises questions of response.

PEER WORKERS MAY BE MORE APPROPRIATE AND HAVE GREATER LIVED EXPERIENCE.

HOUSING AND HOMELESSNESS.

DOING IT ROUGH (SLEEPING ON THE STREET) OR SOMEONE'S COUCH PLACE TO PLACE EVEN WITHOUT ADEQUATE INCOME MAY APPLY MORE SPECIFICALLY TO YOUTH.

PLANNING AND ttRANSITION

sUPPORT NEEDS TO BE CONSIDERED ACROSS SUPPORTIVE LEVELS MUST APPLY ACROSS HOUSING, INCOME, TRANSPORT AND OTHER AREAS

aCCESS AND ELIGIBILITY FOR INCOME SUPPORT IS A KEY ISSUES AS INCOME, HOUSING, TRANSPORT AN COMMUNICATION BECOME STARTING POINTS.

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  SOCIAL Participation and Inclusion

Engagement in any positive mental health activity may involve skills or other education training, opportunity , transport, costs or risks. Guidance or mentoring may be needed. Despite up and down hours due to health issues this resource may be a resourceful and renewable asset.

Justice

Co-responder programs, independent advocates, peer workers represent a useful and helpful resource. Lived experience provides rreality at the coal face with some having court or prison spaces in their history.

Inclusion must be win-win.

Co-ordination and integration

All of us may have diminished, fair , good or strong mental heallth as part of our normal health. Gaps and shortages depends upon resource allocation and usage and federal/state relations remains a dilemma .Sadly COAG places policy and co-odrdination at higher levels but economic and social reality continue to cause havoc.

LETS START WITH BEING EGALITARIAN, THE LIVED EXPERIENCE BEING THE EXPERT AND DUTY OF CARE OWED TO ALL CITIZENS.

ONE MUST OWN THEIR PLAN AND BE RIGHT FOR THEM, phns, ngo, gps and the tertiary sector should support their care decisions. Lets have contingencies mutually agreed.

Psycho-social disability will have environment s of a common nature hours

and circumstances negotiated.

MONITORING AND Reporting One woman I know was kept on an ITO for years and written up as hundreds of admissions because each ECT was seen as an admission. Two actually admissions really occurred. Clients on orders do not receive proper recovery attention. Lesser incidents of relapse occur when one factors in personal recovery in community life..

Eligibility and access will continue to apply as clients exceed beds.
Stephen Graham Brown
Social worker (ret), educator, consumer, carer and advocate. 29/3/2019