SUBMISSION TO THE PRODUCTIVITY COMMISSION ISSUES PAPER:

THE SOCIAL AND ECONOMIC BENEFITS OF IMPROVING MENTAL HEALTH

Joe Calleja

Recovery Matters

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Introduction:

The comments made in this paper are brief and based on my experience as a CEO and advocate within the mental health and suicide prevention sector. The purpose of this paper is primarily to advise of other resources the Productivity Commission might access as there is significant other information available in international and Australian settings that can additionally inform its work.

Assessing Current and potential interventions to improve mental health outcomes.

The assessment approach outlined by the Productivity Commission still assumes that the current diagnostic approach is a sound foundation for responding to mental health problems. I have attached a paper (Attachment 1 and slides Attachment 2) I delivered on line to the Suicide Prevention Summit on 12 April which challenges the assumptions of current interventions and which is therefore relevant to the Productivity Commissions request for a response to its assessment process. While I am not suggesting we throw the baby out with the bath water, the current diagnostic, top down approach of the system has been found not to make productive gains either in suicide prevention or in mental health. How can this be seen to be effective when suicide rates continue to increase in spite of having hundreds of millions of dollars invested by governments each year for decades?

The papers I have attached have relevance to questions throughout the Productivity Commissions Issue Paper.

Questions on Structural Weakness in Healthcare.

One of the major reasons for the failure of the current health system, apart from the failure to adequately address prevention and early intervention, is the concentration of resources within the acute mental health system and the heavy reliance on narrowly prescribed research agendas.

In spite of the plethora of peer based services in the US and UK which are seen to save governments money and provide a hope based positive response to people with mental health issues and suicidal thoughts, Australia remains captured by the belief that the only legitimate service models are those run by government and which are delivered by health professionals. I would be happy to provide further details, however organisations such as Rose House, Community Access and the Western Massachusetts Recovery Learning Community in the US are examples of cutting edge services that create positive change in mental health and suicide prevention and are saving governments significant money, plus keeping people alive and well.

Dr Rachel Perkins OBE Rachel Perkins in the UK who was previously a consultant to the UK government on mental health, disability and employment, is herself a person with a lived experience and has run Quality and Safety Units in National Health Trusts. Rachel will be in Perth from 24 June – 5 July and Canberra on 8 & 9 July. Her program is very full in both states however you might wish to correspond with her in advance if you would like her insights.

She also introduced the notion of a Recovery College into the UK which is also changing lives and helping prevent re-entry into health services. You might wish to note that the WA government just this week announced $3.6million funding from the Sustainable Health Review Report to set up Recovery Colleges throughout Western Australia based on her model. WA is the only jurisdiction to take this important step. Rachel Perkins has written numerous articles on the value of Peer Support in recovery from mental health problems and its usefulness in reducing costs in the health system plus restoring hope and productivity for individuals with mental health problems.

We have a system which is primarily driven by a belief in the DSM V and ICD Classifications neither of which have any scientific basis – this is now openly being acknowledged by psychiatrists and other professionals, yet still remains the cornerstone of training, research and service delivery. This means current problems will be perpetuated in spite of anything the Productivity Commission recommends if this conceptual framework remains as the cornerstone.

In relation to psychosis I note the Productivity Commission has not sourced the work of Professor Dr Marius Romme a Dutch psychiatrist who with Patsy Hague, his patient, developed the Hearing Voices approach in 1987. This is now widely used in Europe, the UK and USA and Australia. It offers a peer led response to psychosis which helps keep people well and outside of services. It sits alongside current diagnostic (pathologizing) approaches in the Australian government and non-government settings.

At least the ICD is about to recognise there are social determinants which contribute to mental health and suicide and this is a significant shift.

Questions on health workforce and informal carers

There is a long overdue need to grow the peer workforce in Australia. This workforce should not be considered to be second rate or simply an add on to the existing workforce. Instead it should be developed as part of a team of health professionals seeking to assist those in distress. The failures of previous attempts by governments to grow the peer workforce – very minimalist and sporadic attempts – have largely been because one peer has been dropped into a team of professionals who generally did not understand or value their role. Hence they burn out or become discredited.

In relation to health professionals, the key change required is they actually listen to the distress of their "patients" rather than simply use check lists or apply diagnostic and pathologizing responses. The problem with the professions today is they have taken

a completely siloed approach to their work taking ownership of “their bit” at the expense of recognising the individual and his or her need.

In relation to GPs, they are known to prescribe medications at a higher rate than psychiatrists,. They are inadvertently contributing to an exponential growth in diabetes and other health related problems experienced by people with mental health problems. Medication does not deal with trauma or distress which is what is most often at the source of people experiencing mental health problems. It is critical that PHNs and the various Colleges move GPs away from an almost exclusively diagnostic approach to responding to mental health issues.

Questions on housing and homelessness

I was surprised not to see reference to the work locally or internationally on housing and homelessness and would encourage exploration of https://www.micah.org/ and also the National Alliance to end Homelessness. You might already have some of this information from consultations you have already undertaken. I would also encourage you to look at the work of Community Access in the US and Calgary in Canada as there approach is evidence based.

Income support and social services

It is evident that Newstart is intended to take people of other social security payments and put them into the workforce. However, both the low rate of income it provides and the blunt edge nature it is as an instrument have probably damaged more people than it was supposed to assist. It has likely contributed to other costs such as health costs by virtue of the range of additional problems it has created or compounded.

The NDIS was never intended to help people with mental health problems. The original Productivity Commission report only had ten pages on mental health out of one thousand pages in its report. The legislation has locked in a requirement of permanent disability when the whole mental health sector is working towards hope, recovery and social inclusion. State governments rushed to dump their money into NDIS to get out of providing state services. The Commonwealth dumped specific mental health funded services such as PHaMS and Partners In Recovery into NDIS when only a fraction of those currently receiving services from those programs would later be eligible for NDIS. Those who miss out later would simply reappear in emergency departments of state hospitals – a simple unintended (?) form of cost transfer from the commonwealth to the state. However, more importantly, thousands are now missing out on services that were helping them and are now in limbo and in deeper distress.

Questions on social participation and social inclusion

I would again draw your attention to the work of Rachel Perkins. I have included her details below as you can see there is considerable work already being undertaken in the UK that can inform your deliberations:

Rachel Perkins BA, MPhil (Clinical Psychology), PhD, OBE

Senior Consultant, Implementing Recovery through Organisational Change (ImROC)

Co-editor of 'Mental Health and Social Inclusion'

Chair, Disability Advisory Group of the Equality and Human Rights Commission

Chair of IPS London Network

Non-Executive Director: The Recovery Focus Group and Health Employment Partnership

I do not believe there is any government state or commonwealth in Australia that is seriously undertaking any work in these areas.

Justice

A key change required for all governments is to ensure that the health authority is the provider of health services within the justice system. In Western Australia the Justice Department manages Health services and this has resulted in negligence and damage to prisoners as reported by the Inspector of Custodial Services.

The START program run jointly by the police and Health in WA is an excellent response to community based issues.

Child protection

The removal of children from care is sometimes as traumatic as their experience of abuse within the family or by others. If the state has taken on the role as guardian it must behave as a responsible guardian, yet there is very little evidence in Australia that statutory authorities actually directly address childhood trauma for those in their care. Significant benefits would arise if child protection authorities actually provided wrap around services for children in care rather than put them on a long waiting list to be seen by mental health services, or simply refer them to in house psychological services that only attend to one to one counselling when in fact a broader support is required.

Questions on education and training

One of the key contributors to mental health problems in later life and suicide is bullying experienced at school. I wonder how many school principals would increase their attention to this problem and hold their teachers accountable to actively deal with known school yard bullying if Principals and teachers were the subject of civil action through the courts for their failure to deal with this issue? I suspect many teachers and principals pay a token regard and consider such behaviours as being slightly out of control normal behaviour of childhood and adolescence.

There is a Youth Recovery College in Melbourne that might provide an additional model to existing educational strategies for young people.

Questions on government funded employment support

By now the Productivity Commission secretariat will have come across the Individualised Personal Support program which is focussed on providing people with mental health problems with employment skills. Professor Richard Warner (now deceased) was a US based psychiatrist who produced some early evidence informed literature on the benefits of employment for people with mental health problems. Rachel Perkins who has been mentioned earlier has undertaken extensive work on this in the UK and has been a consultant to the UK government on this issue and in Australia Professor Geoffrey Waghorn is a key researcher and proponent of this approach.. The Commonwealth government has provided some financial support for the work currently being undertaken by WAAMH in Western Australia on this issue.

Conclusion

I have not attempted to cover all aspects of the issues covered in the Productivity Commission Issues paper. However, I look forward to responding to the above and other matters in the subsequent discussion paper that will be released later this year.

Joe Calleja

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