SENATE SELECT COMMITTEE ON MENTAL HEALTH

1) Suicide prevention pamphlet

Suicide prevention in Australia has been centred on several approaches and has been associated with a significant fall in suicide rates in the period 1997 – 2003. The strategies include a multitude of projects to increase intra community connectedness and community support. The strategies also include reducing the means of suicide and improving early detection of warning signs, including the improved recognition of depression.

The glaring omission in our multi pronged approach in our multi pronged attack on suicidal rates is the lack of attention given to people who have current suicidal thoughts or who belong to a high risk group.

This lack of attention is exemplified in the absence of material that may enhance their chances of survival. In fact, it would appear that this is an international failing as I have yet to discover any simple, cheap pamphlets in Australia or overseas. There are a couple of booklets put out by organisations in Australia and the USA on depression but these are 20 pages too long and too expensive.

The Toughin' it out pamphlet has been used in the contexts of general practice, youth services, mental health services, drug and alcohol services and Indigenous health (both urban and remote) for a number of years. The information is very accessible and quite self explanatory.

Basically, it attempts to counter 'impulsivity' to buy time for the crisis to pass and to allow other supports to be mobilised, for medication to take effect etc.

As well as being a clinical tool for people with suicidal thoughts, the pamphlet has a valuable role in suicide prevention. Because of the impulsive nature of many suicides, especially with youth and young men, relying on others to pick warning signs is often not effective. What makes more sense is that the community in general has the knowledge of how to deal with suicidal thoughts. In particular, those in high risk groups need to be prepared in case suicidal ideation enters their life.

This raises the possibility of targeting these high risk groups to ensure that they have been exposed to the information in the pamphlet.

Targeting would involve:

- Inclusion of the material into the MindMatters curriculum in secondary schools.

- Introduction of the material into mental health services, especially into in-patient facilities and into routine discharge preparation.
- Introduction into drug and alcohol agencies.
- Introduction into the Family Court.

2) Early Intervention

Mental health services are still far too reactive as they are still focussed on people with established mental health disorders. Even these people are diagnosed late with the average gap between onset of symptoms and diagnosis being two years.

Detecting problems earlier means that the impact of the illness on self confidence, on a sense of control and on their ability to socialise are minimised.

An appropriate place to target early intervention programs is in secondary schools. The MindMatters program exists as a vehicle for disseminating such information in schools.

I think that this information needs to be expanded to include:

- Strategies for dealing with suicidal thoughts
- Early signs of psychosis and the relationship with illicit drugs
- The impact of childhood emotional, physical and sexual abuse

The last point is particularly important because many teenagers, who have had this childhood experience, will go onto having mental health problems, drug addiction problems, problems with low self esteem, a tendency to self blame and a dislike for self as well as relationship problems.

I have counselled many such individuals but this often done in their late 20s to 40s, when they have had years of damage. It is rare for these things to have been addressed during the teenage years, when they may have gained some insight into why they thought and behaved the way they did. Instead, the connection between odd, problematic behaviour or problematic moods and their past is not made and they see themselves as ‘mad’ or ‘bad’ of ‘different’.

Being able to normalise this reaction to such a background by having knowledge about the issue allows then to be more self empathic. It allows them to move on and turn the behaviour around.

3) Developing countries and mental health

Internationally, it is well established that outcomes in mental health are considerably better in developing countries compared to industrialised countries.

Unfortunately, the tradition in mental health has been to cast an eye in the direction of the USA or Europe despite the fact that these countries have the worst outcomes. Largely, we ignore the lessons from the developing world that we could incorporate into our system, despite our cultural differences.

So, what may we learn? Community involvement in treatment and recovery appears to be a major factor. Because there are very few mental health facilities, personnel and programs, the consumer is integrated into the normally functioning community, rather than being clumped together with others involved in the same struggle with inappropriate behaviour etc.

Because of the lack of a welfare system and the availability of low skilled part time work in the fields, work is thought to play a major par in recovery. In our culture, because there are fewer unskilled jobs, returning to the workforce may involve preparation programs, relearning or upskilling, as well as an understanding employer.

The other major contributor to better outcomes is thought to be the reduced degree of societal stigma. Having poorer outcomes and having little contact with people who have a serious mental health disorder has led to an unfortunate degree of community fear, mythology and negative approach to those who have a mental illness.

Therefore, we need mass media approaches which tackle community falsehoods and which enhance community knowledge of these issues. Monitoring the media is an important factor in this process.

Far more success stories need to see the light of day for people to discover what is possible in life, despite having a mental illness. A recent publication, "A Lifelong Journey. Staying well with bipolar disorder." by Sarah Russell in which 100 people describe the strategies that allow them to have successful careers, despite having bipolar disorder is a move in the right direction.

Current thinking is that the community response to mental health issues determines outcome far more than the pathology of the illness itself, medication, therapies etc. This 'Cultural Model' suggest that if the culture is supportive and involved, then the severity and duration of illness is greatly reduced.

4) Consumer Representation

So far in Australia, consumer representation has been dominated by representation of consumers from the heavy end of the outcome spectrum. This end comprises of people whose mental health disorder has been chronic and very damaging. Consequently, this group is frequently struggling to recover and is frequently unemployed.

Participation in the consumer movement has often been helpful to their recovery. Participating in representative positions is often a part of their recovery process, even

though there is an expectation that will participate in a voluntary capacity, even though for some it is no easy matter to keep up with the need to read and interpret a large volume of material and even though they frequently have a sense that there position borders on the tokenistic.

The consumer representation movement fails to represent the sector of consumers who have far better outcomes, which often means that they are in full or part time employment.

This is a pity for a number of reasons.

- There capacity to contribute to mental health organisations is enhanced by their own capacity to grasp the issues
- The own mental stability means they are less likely to miss meetings.
- Their own self esteem and self confidence allows them to state their case in often intimidating circumstances.
- As professionals they may have a solid knowledge of medicine, the law, organisations, finance, the way the community works, political contacts ie they can act as a considerable resource that is not constrained by those that constrain employees of the health system.
- They present a different face of mental ill health to the community.

This last point is perhaps the most important. Social stigma is one of the greatest negative influences on outcome in Australia. This needs to be challenged by the promotion of positive outcomes. These examples are plentiful but well hidden. If this more optimistic approach to outcome is promoted, then expectations of outcome rise. This also means it is harder to underfund services if this means not achieving what is possible. However, currently, because the public are so accepting of poor outcomes due to their biased contact with mental health, they have a perception that putting in more funds is a waste of time.

The other flow on is that more optimistic approaches to recovery for mental health patients has been shown to impact positively on outcome. The developing world experience is a case in point. This applies across the medical spectrum, not just in mental health. A patient with a positive attitude to outcome does better no matter what the illness.

So, what constrains the participation of this sector of mental health consumers?

- Because of social stigma, membership of this particular club is not something that you want to hold onto. You would much rather put it behind you.
- A fear, based on reality, of consequences in the work setting if you go public on your own mental health issues. This may be in terms of finding employment difficult or it may be something that discourages having a successful business and discourages clients from trusting you.
- Meetings with mental health services are often held within business hours to suit salaried health workers. As the expectation has been that consumers' involvement is voluntary, then the consumer has to wear the cost of being absent

from work. Usually, it means that they are the only one in the room who isn't being paid and this, in itself is a statement about worth.

To turn this around several steps could be taken:

- Consumers should be paid a base rate for their time if unemployed and a rate to cover loss of income or costs if employed. Budgets then need to incorporate these costs.
- Meetings should be held at more convenient times if committees are serious about engaging this spectrum of the consumer movement.
- Those who are getting on well with their lives should be encouraged to participate more in the consumer movement as a valuable contribution to the improvement of mental health outcomes.
- A media campaign in a similar vein to the New Zealand experience should be mounted to challenge public expectation of outcome in mental health.
- More resources need to be channelled into promoting positive outcomes. "A Lifelong Journey. Staying well with Manic Depression/Bipolar Disorder" by the Melbourne author, Sarah Russell is a classic example of this.

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