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Secretary
House of Representatives Standing Committee on Education & Employment

INQUIRY INTO MENTAL HEALTH AND EDUCATION, TRAINING & WORKFORCE PARTICIPATION

I aim to limit my focus to the preventative elements of:

"strategies to improve the capacity of individuals, families, community members, co-workers and employers to respond to the needs of people with mental ill health."

with comments and recommendations throughout. I hope that approach is both reader-friendly and value-added to the tasks before you.

I early retired in 2000 (see attached), co-incidentally when the reform blueprint, the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 was produced. That's when the clock started for me given the government's acknowledgement that its action plan requires "...*commitment from all sectors of the community*." It also promised to tackle increasing 'mental health' awareness – the pre-requisite to increasing mental health literacy. (*Towards mental health literacy is akin to going* ***beyond mental health awareness101*** *– a phrase I coined some time ago*)

There has been any number of updated, revised national policies, strategic plans, reports since. I don't want to unnecessarily duplicate the effort that went into them but I do want the Committee to identify do-able tasks, not stay with the traditional too-broad and feel-good strategies that remain too difficult to "audit" for successes.

For me an **umbrella recommendation** to you is to challenge status quo so that the next report – your Committee's – actually has an '*outcome*' ie defined as *"....a measurable change in the health of an individual...."*.

Whatever is both done and not (yet) done needs to be far more accountable, measurable and 'program-managed'. Committees and Plans advise with all care and no responsibility for any task. In the current 5-year COAG Mental Health Plan 2006-2011, only 3 government agencies were given tasks. Maybe unfairly, but after a decade this means most government agencies may claim they do not need mental health action plans so don't need to either explain why or "share the wealth" if strategies are successful.

Knowing is not enough; we must apply. Willing is not enough; we must do.
(Johann Wolfgang von Goethe)

CONSIDER THE ENVIRONMENT:

We seem to gloss over the umbrella term of '*mental illness*' as if we can somehow come up with the one '*universal prevention intervention'* strategy that works for all. Government agencies confuse personal service (that they variably deliver) with personalised service they cannot deliver to all who need it; political will, funds and resources and "consumer compliance" dictating.

So, there will always be friction between the process and the program. Mixed messages, unmet needs and unreasonable expectations exist on all sides. Any 'mental health' strategy remains a soft policy at very high risk every time another elephant crowds the room. This is a challenge for us all and more so for those at risk of mental health problems if expectations are not realised.

I believe there are at least 3 sides to each coin. If one managed a workforce participation program with a mental health element, different and maybe conflicting priorities and competing responsibilities exist than if it was a mental health program with a workforce participation element to it. The Federal Budget has a "national mental health reform" element to it and a dual purpose to reduce income support expenditure. There is no single simplistic cause why people on DSP stay on DSP. What framework will underpin all strategies arising from your Inquiry and will there be functional over-riding portfolio responsibility.

Even decision-makers can be confused about mental illness. A diagnosis of a specific mental illness may likely lead to an ADL impairment, probably to a disability and possibly to a broader incapacity, certainly if untreated. But the diagnosis per se should not be a reportable "offence" for education, training and employment let alone anything else. There are countless reasons why we ought to give a fair go to another person – their relative mental health is but one of them. OH&S and anti-discrimination laws, better productivity a few more.

A person **at risk** of developing anxiety, depression or "stress" or "adjustment disorder" from whatever underlying triggers - in a robust workplace - is I suspect more often than not, overlooked. If we paid more attention to true preventative strategies, in an ideal peaceful world, the workers compensation industry could self-destruct. But we do need to be fair dinkum about suitable jobs, limiting putting people in mental health harm's way.

This was not intended to be an exhaustive list. State and Federal government employees whether all know it or not have a great database (brainstorming-wise) and could lead by example by being made job-ready for mental health reform ahead of the private sector.

RECOMMENDATIONS:

1: Let this not be just another report. Go back to a source document eg Action Plan 2000 which to me covers prevention more substantively than subsequent reports. "Audit" your findings against the above Action Plan – in context specifically actions and outcome indicators identified at pages 22-51 of that Plan so that do-able tasks can be identified for the broader community.

2: Review the quality and quantity of what is being done in the area of increasing 'mental health resilience' with a view to expanding that program. NSW Education's PDHPE syllabus for primary and secondary school students is age appropriate but may be time poor and allow students to opt out of "tougher" topics when examined. This is purely a preventative strategy that really needs to succeed.

3: Review the quality and quantity of what is being done in the area of increasing 'mental health literacy' with a view to expanding that program. The Mental Health First Aid Certificate course is accredited for that explicit purpose, widely applicable* and can be adapted to its audience.

(*I recommended to Centrelink years ago that they participate in this program so I hope I had some influence. I suggested that their First Aid Officers broaden their skills base - it could be made a First Aid Diploma with a higher allowance. Of course, Centrelink, with accredited trainers could by now run an adapted course in-house. Centrelink did roll out this program so must be able to comment on its value to them, their staff, customers. This is "mental health reform" but is probably hidden from that program by being funded from their T&SD budget.

*Remind Mental Health Training & Education also deliver this training using accredited consumer and mental health educators. Other organisations probably do too but there is no global analysis or sharing the wealth, fine tuning etc. I don't know where this funding is included in the Budget)

4: The mental health program for this broad area seems to be fragmented so that its full extent is unknown. How will the strategies the committee identifies expect to be managed and measured against performance indicators?

I doubt the Federal Minister for Mental Health currently has specific portfolio responsibility for this given his portfolio's focus on mental ill-health **– but he should**. I submit strategies have a better chance of success if one agency was responsible for the framework and EVERY government agency had tasks and accountability. The Mental Health Commission should have more visible teeth.

ATTACHMENT

I hope the following personal snapshot adds some context and street cred:

Amongst other things, I have worked for DSS as its sole and senior disability policy officer for NSW including close liaison with senior medical officers, as an Assistant Director in DSS Social Policy Division working on alternative assessments including assisting the Ministerial Impairment Review Panel, as the first manager in the inaugural staff support unit - Work Environment Unit - in NSW's then problematic Area West and in Centrelink as an Authorised Review Officer specialising in all disability-based payments.

Since early retirement in 2000, I have been a voluntary, freelance mental health policy advocate, completed a 2-day ANU-residential Mental Health First Aid Certificate course and 11 years into retirement, will shortly complete a Diploma in Health Counselling.

DEFINITIONS:

The terms 'mental health' and 'prevention' continue to be lazily applied. I have relied on approved definitions. Without repeating them all, I'll provide a few for your ready reference:

Mental health literacy
The ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes; of self-treatments and of professional help available, and attitudes that promote recognition and appropriate help-seeking.

(Mental Health) resilience
Capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk of adverse health outcomes. Factors that contribute to resilience include personal coping skills and strategies for dealing with adversity, such as problem solving, good communication and social skills, optimistic thinking, and help-seeking. (A more concise definition exists but temporarily unavailable)

Prevention (abbrev)
Interventions that occur before the initial onset of a 'disorder'.
This provides criteria for 'universal', 'selective' and' indicated' preventions.

Jeff Munday

4 June 2011

BEYOND MENTAL HEALTH AWARENESS101

HOUSE OF REPRESENTATIVES COMMITTEE ON EDUCATION & EMPLOYMENT

Inquiry into mental health, education & workplace participation

A response by Jeffrey Munday

We do not seem to learn from earlier studies and reports except to perhaps harden our hearts, listen without hearing, and glaze our eyes as a protective instinct. There was for example a report in 2004 entitled: 'Investing In Australia's Future'. That report notes *"...a lack of community support for ongoing reform*..." and despite whatever efforts are being made, the report notes the community remains "*ill-informed*". Despite the experts concerns, un-measured strategies are still used. The report notes:

"This report focuses on the need to shift thinking, recognise new challenges and implement new ways forward." "....By accident or by design, we are all responsible for this situation...."

Every government decision involves compromise thus "collateral damage". If all else fails in the 'mental health sector' everyone, including those outside of it, ought to at least aim to encourage, develop and increase our 'resilience'. And governments ought to better collect qualitative and quantitative data to measure the actual and opportunity costs.

My submission to you has a positive intent. "Attacks" are aimed at any lethargy, the status quo and are more self-directed towards my own impatience rather than to any government of the day. I've taken the opportunity to update the definitions in the attachment.

Jeff Munday

11 June 2011

"I don't know all the questions, let alone have all the answers."
(J Munday 2011)

BEYOND MENTAL HEALTH AWARENESS101

Committee Secretariat
House of Representatives Standing Committee on Education & Employment

Inquiry into mental health education & workplace participation

INTRODUCTION

This is supplementary to my first submission No: 51 and I can see my approach is different to other submissions to this Inquiry. I hope it is value-added.

I see a lazy use of the term 'mental health' by the 'mental health' sector et al** but also limited attention given to extending 'prevention intervention' strategies beyond medical research and anti-stigma awareness101. Prevention intervention strategies are distinct from 'early' intervention programs, the latter aimed at reacting to emerging and chronic, mental health problems. Even '*early*' intervention has a qualified definition.

I'm risking belabouring the point unnecessarily but I don't see great inroads.

Blaming "stigma" only takes us so far. To stigmatise may actually breach the Disability Discrimination Act but it would take a very brave person to seek such redress. Are there structural barriers based on what I call "*mental health lipoplasty"*? Why do governments make qualified statements where many questions go begging? (Why is Parliament's Question Time not its Answer Time for the common folk?)

COAG's National Action Plan on Mental Health 2006 – 2011accepts, like motherhood, a need for "promotion, prevention and early intervention" yet allocates functional detail only to interventions for mental illness at an agency or program level. Many reports with none consolidated?

An earlier COAG reported "....*it is not reasonable to expect that everyone will experience good mental health all the time....*"

My immediate (and recorded) thought at the time was: "*So, what is a reasonable expectation for the incidence of good mental health in our community? 50% of us for 50% of the time and how/where/why do we determine who misses out?"*

Am I unfair in citing Bill Shorten's global-issue article in The Saturday Telegraph 11/6/2011: "....*While the government should not adjudicate every argument - sometimes you need to take responsibility for your own actions*...."

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While Minister Shorten's statement is worrisome in the public domain, my take is It can't be realistically expected that when the innocent walk in mental health's harm's way they will always remain unscathed. Certainly, the taxpayers' finite dollars will never be enough, nor will any attempt to gain a consistent good will of the people. But as in all things, if we accept status quo in retaining good mental health, we are simply hoping for increased resilience without a preventive action plan.

Fail to plan, plan to fail.

Therein lies the good mental health "challenge" or conundrum. Lest you think I'm unduly pedantic or playing semantics, let me finally cite a group with a far greater skills and resource base than I:

***"....Recent data collected by WHO demonstrates the large gap that exists between the burden caused by mental health problems and the resources available in countries to prevent and treat them (WHO, 2001a). In contrast to the overall health gains of the world's populations in recent decades, the burden of mental illness has grown (Desjarlais et al., 1995; Eisenberg, 1998).*

This neglect is based at least in part on confusion and false assumptions about the separate concepts of mental health and mental illness. Until now, the prevailing stigma surrounding mental illness has encouraged the euphemistic use of the term "mental health" to describe treatment and support services for people with mental illness. This usage adds to confusion about the concept of mental health as well as that of mental illness....."

(Extract from Chapter 1 of 'Promoting Mental Health-Concepts-Emerging evidence–Practice' A Report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and The University of Melbourne WHO 2005)

My interests in mental health and illness go back a lifetime. In my career, I've tackled many aspects across the full spectrum of your Inquiry. I have, as one example, managed a staff support unit, lodged a workers compensation claim despite the executive, and advocated on behalf of people claiming and appealing claims for the DSP. There are at least 3 sides to every coin.

In 1989, I presented a paper to the After Care Association's conference: 'People, Employment, Mental Illness: "A Confrontation" at the Westmead Centre. My paper focused on practical advice but included: "*Don't let the*

bastards get you down." where the 'bastards' of the process were both human and the other barriers caused by the friction between processes and programs.

My bosses instilled in me the ideas of personalised service if possible or best customer service, and an outcome and continuous improvement focus. This is part of the "baggage" I brought into my early retirement.

An **outcome** is not a plan or policy despite what may be hard won arguments and compromises that got us there. Nor is it seen in the countless generalisations that appear in programs when they are subject to extensive exceptions in its criteria. Let us walk one human through our theoretical program to reality check it. An "average" human does not exist.

I accept the oft overlooked definition of *'outcome' is as* I've provided in the attachment.

I do not accept all those who are dependent on public-funded programs have a selfish sense of 'entitlement' but will review that once governments' mixed messages cease to exist. I accept the government does not have a bottomless pit of money let alone a saucer full. In fact, the government, collectively and individually, are caretakers of our money.

And by what core belief system do Australians need to be compensated (funded) to give someone else a fair go. In all this, I use the inclusive Royal 'we'.

JEFF MUNDAY

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FURTHER COMMENT:

My comments aim to overlap, to cover the spectrum as education and training occur in the 'classroom', workforce....and in life. If we are to be fair dinkum about helping people with existing mental health problems, illness or disability to (re)enter the workforce, the prevention intervention approach may well be to first ask does that specific field of employment have a climate conducive to good mental health.

If not:

- The person with mental illness may need, and be limited to, support ranging from one-off job-seeking advocacy, confidence/self-esteem building through to ongoing mentoring. A benevolent employer or supported employment vs the greater independence of open competitive employment.

- Any taxpayer funded support to do this is by definition limited. This spotlights the gap of unmet need. Ergo the taxpayer, community and government have by default decided in the negative for those left out. Unrealistic expectations will exacerbate unmet need even if the consumer is unaware of this jargon. The 'consumer' can be inadvertently set up to fail.

If so

- We have a specific field of employment whose best practices need to be identified by task and shared.

What about the NGOs...they're all paid....leave them to their own devices? Mental Health Resilience and Mental Health Literacy based-programs (in fact all education and job-seeking programs) are usually run by very busy NGOs and others. Continuous improvement (or its current jargon) demands ongoing evaluation, fine-tuning. Updated into national action plans in sufficient detail that the wealth is shared is a forgotten dual program purpose. NGOs are flat out fighting for their first or next instalment of funds. They may not provide frank feedback if at risk of being held to ransom given the millions of dollars on offer – subject to performance - in a highly competitive mental health industry. There needs to be a partnership and liaison role providing support to ensure success and that taxpayer funds are not 'Titanic-monitored' ie after they're spent.

Is it thinking that far outside the box to put more energy into true prevention intervention strategies? Forget the human welfare, it is good business practice to keep an employee or student focused and compensation and retraining (new employees) down. How much political will exists to drill down further when the government is a major employer and educator?

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The following comments aim to drill down but are not exhaustive:

Mental Health Impact Statements may, by other names or processes be done intuitively. If it doesn't work for the staff at risk, how is it expected to work differently for the 'consumer'? If government bills or laws need to be re-jigged because of "unforeseen" consequences, properly designed Impact Statements, the mental health (MH) EIS approach should at least be studied, if not trialled.

The MHIS can be applied to all relevant aspects of government programs so that we know if it will be MH cost neutral, risks worsening MH or should improve resilience. This can start with 'passive' data collection only.

OH&S: When a good understanding of OH&S is a selection criterion for a job – as it should be – applicants give it their best shot and the selection panel or decision-maker rate their answer. But what if the panel itself had to explain why they were satisfied with the (from experience) poor answers. OH&S is a soft policy skill when compared to the much needed technical skills to do the day to day tasks. So, when a successful applicant with a lousy functional knowledge of OH&S deals with an employee with mental health problems or at risk of acquiring them, what checks and balances exist?

Mental Health Intervention Team (MHIT): NSW Police have decided the MHIT is a valuable additional resource for them in reactive management. While its purpose is to limited to better deal with mentally disabled potential offenders and related public disturbances, the training increases the mental health literacy of police which is an internal OH&S and prevention intervention strategy. If its dual value is realised, maybe a higher priority could be afforded its rollout: "....*Our goal is to train 10% of all NSWPF operational police by the end of 2015....*" And those who are not available for the MHIT won't have wasted skills.

Centrelink: remain a good example in a number of ways. Their review process continuously aims to get it right for their customers and given their core business, internal training programs to try to ensure all staff are job-skills compatible, and burgeoning costs to the taxpayer do see there are more than 3 sides to every coin.

Immigration: deal with asylum seekers in distress and the staff and medical professionals largely impotent to remove them from harm's way. Do we accept the phenomenon of 'burnout'? See MHIS above.

Parliament, magistrates etc: There is an entrenched estimate that 20% of us will develop a mental health problem. What risks are faced by members of parliament etc who have not been "outed" given the hard time faced by those who have? And what lessons or mixed messages do the public gain? See MHIS above - if we can't look after those who represent or protect us?

BEYOND MENTAL HEALTH AWARENESS101

ATTACHMENT

DEFINITIONS:

Mental health literacy:

The ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes; of self-treatments and of professional help available, and attitudes that promote recognition and appropriate help-seeking. (Jorm et al 1997)

Mental health lipoplasty:

A procedure that sounds great on paper for effect and takes up time but only gives "lip service" to the achievement of any meaningful outcomes. (J Munday 2011)

(Mental Health) resilience:

Resilience – the capacity to cope with change and challenge, and to bounce back during difficult times. (MindMatters)

Outcome:

A measurable change in the health of an individual, or group of people or population, which is attributable to an intervention or series of interventions. (Australian Health Ministers 1998, p27)

Prevention:

Interventions that occur **before** the initial onset of a 'disorder':

Universal intervention 'targeted to the general public…that has not been identified on the basis of individual risk.

Selective intervention 'targeted to individuals or a subgroup of the population whose risk of developing mental disorders is significantly higher than average.

Indicated intervention 'targeted to high-risk individuals who have minimal but detectable signs and symptoms foreshadowing mental disorders..but who do not meet DSM 1V diagnostic levels at the current time….