Fiona Wood Public Lecture Series

Transcript for 'Demystifying mental health: causes, treatment and recovery'

Presented by Anthony Collier and Steve Batson

Anthony:
We would also like to acknowledge the traditional owners of the land on which we meet and pay our respects to the Elders past, present and emerging. In addition I would like to acknowledge the lived experience of people who have a mental illness.

Automatically assigning the label crazy or depressed or unstable does a great disservice to people who live with a mental illness every day. Equally the new emerging trend, particularly through social media, of beautiful suffering also misrepresents the lived experience of those with a mental illness.

Tonight we acknowledge that there may be many people in the audience who have had personal experience with mental illness or one of their loved ones have had mental illness. We thank you for coming and we hope tonight that we are able to just unpick a few themes and unravel a little bit about mental illness.

May I just reiterate what Fiona said, that outside we have both HelpingMinds and Lifeline if there is anything in the conversation that we have tonight that distresses anybody and they are there for supports.

One of the things that Steve and I wanted to do tonight was having an opening conversation, and we think it is very important in an opening conversation that this is a better dialogue and we are here to represent that this conversation is about listening and it is about mutual respect.

Steve:
We hope to cover the areas of understanding what we mean by mental health, mental illness, mental wellbeing. We are going to try and present a framework that we hope will help inform a shared understanding of mental health and the mental health system and finally we are going to look to the future, to where we think mental health and where the community can help take mental health.

Anthony:
So Steve, as a starting point, mentally ill, what are we talking about?

Steve:
I think when I hear the phrase mental ill or mental health or mental wellbeing, I probably have a different interpretation of what those words mean than maybe you do, and I expect other people in the room probably have different images that come to mind when we use those kind of phrases. So, it would probably be helpful for us to explore the impact of language on how we formed interpretations of what mental illness is and what mental health is as a starting point of this conversation. If we look to our everyday conversation we use phrases relating to mental illness, usually disparagingly, in everyday life. They have become socially acceptable and that is kind of a bit unusual.

Anthony:
Like mad as a cut snake or something like that.

Steve:
A classic Australian phrase.

Anthony:
Yep.

Steve:
You're a psycho, he's crazy. We've both been referred to as insanely good looking for example. And it's interesting because in other areas of health, medical phrases have been seen as being socially unacceptable. We wouldn't use phrases around disability anymore, maybe 30/40 years ago, but mental health phrases seem to through our social media, our social conversations, our printed media.

We have people labelled as being mad, get the crazies off our street, in newspaper headlines. In the films that we watch, we see portrayals of mental illness or mental health problems that have no relevance to the diagnostic criteria for those illnesses.

Anthony:
Steve in addition to the media, and we get it through films, we get it through even things which are not related to mental illness, we've got a little example up there about describing weather in mental illness terms.

Steve:
Oh yeah, well the Melbourne weather is schizophrenic, that's a phrase I heard when I got off the plane. Australian cricket probably is in crisis and that might be an appropriate use of the word there – it certainly needs some professional help, not as good as the English cricket.

Anthony:
There's also very much the personal understanding, and that in my experience influences probably as much or maybe even more than what the media is demonstrating.

Steve:
Yes, interestingly we have had a few conversations in preparation for this and been referring to people's family history, and a common theme seems to be that most people have a member of the family, maybe a few generations back, that was seen as a bit special, was a bit odd, had a breakdown, was in the local asylum, and that shapes a family view of what mental illness is based on; aunt Edna or uncle Frank.

And there's a tendency to look at family trees and do some research, that seems to be quite fashionable at the minute, so we understand and unpick some of those people's life histories. We are learning that actually these people were victims of child sexual abuse. There was the trauma from Second World War or more recent conflicts the Vietnam War. That they may well be struggling with their sexual identity, might have been lesbian or gay and that wasn't socially acceptable. They might have been transgender and there wasn't a way of explaining that – living an oppressed and suppressed life that caused them to have.

Anthony:
And Steve, all those factors are with us now, we've just had the Royal Commission into sexual abuse, we've had the vote nationally about gay marriage, etcetera. So we are just getting permission to bring those things to the fore now.

Steve:
Yes absolutely. They're becoming a national conversation. We also need to recognise that we're a multinational country. This country is mainly an immigrant based population and we've got people from all round the world. And different cultures express their mental ill health differently.

Research from Stanford University demonstrated that some Indian subcontinent areas and some African countries, people tended to hear voices differently to mainstream Western culture. In those countries people's voice hearing experiences were much more of ancestors and of family members telling them good news and giving them advice and guidance, whereas in Western culture it was more likely that they hear negative voices that are aggressive and demeaning. And that's an impact on people's experience of mental health and what that means, they are both areas of hearing voices.

Anthony:
And we know from people from the old Persian empire, Iran and Iraq, for example, they often will experience their symptoms of psychosis through pain in their stomach.

Steve:
Yes, absolutely.

Anthony:
And they will present with physical manifestations of that.

Steve:
Yes. And because language does not have words for mental illness necessarily within some of those cultures, actually expressing it as a mental manifestation to suit a Western model is very difficult and ostracising.

Anthony:
Let's just pause and talk about, you know we did welcome to country, acknowledgement to country when we came here, the experience of the local Noongar nation as well.

Steve:
Yes. It would be impossible for us to talk about the experience of the last 200 years and the impact on our local aboriginal population's mental health in this forum. However, it is interesting to note that the Noongar language did not have words for mental illness prior to the settlement in the late 1700s/early 1800s of Western Australia. And in the last couple of hundred years they have adapted as sick head as a phrase to use for mental health. Traditionally that meant tomfoolery, silly behaviour. So, yeah it's interesting that for tens of thousands of years there wasn't a need for a phrase to mean mental illness.

Anthony:
So we have layers and layers of different understandings, different experience of mental illness or mental health, and I want to go back to what Fiona introduced, we know in Australia which is made up of a very multicultural society and of course with the traditional owners, that one in five people will have a mental health problem at any one time.

Interestingly we also know that over a lifetime 45 per cent of people in Australia will experience a mental health problem, a mental illness, some signs or symptoms. That's a large number of people. I want to break that down a bit more because the numbers are just so enormous when we talk about that. What we have behind us is a picture of Australia and you will see that Western Australia is coloured in purple. When we say one in five, just to help understand the quantum of what that is, that's twice the population, the entire population of Western Australia at any one time will have a mental health problem.

Steve:
That's a phenomenal proportion of the population.

Anthony:
Yeah. So how we can try and deliver services for such a significant amount of people is difficult. So, let's just start and break this down. Of the 20 per cent and this is Australian research which shows 2 to 3 per cent of people will have a severe mental illness. Interestingly only a small proportion of those will have an inpatient experience during that time.

Steve:
And I think it's about one 25th of that, 2 to 3 per cent.

Anthony:
Yep. So it's quite small. And those 2 to 3 per cent will typically come to specialist mental health services, they might come through the Emergency Department, it might be through referral from the GP or whatever.

Then underneath that there is about another 8 per cent of the population which have what we've described as a moderate mental health problem, a moderate mental illness, and that would be people who would typically go to a general practitioner and often will be assigned a mental health care plan and they will often have some type of psychological counselling as well.

They may be treated by the GP for depression from some antidepressives or anxiety. Then underneath that we have about another 9 per cent of the population who will show some signs and symptoms of mental illness and that does not mean the person has a diagnosable mental illness, however has signs and symptoms which are consistent with having problems with their mental health which can lead to that trajectory.

Steve:
So, in that breakdown you're using phrases and words like mild, moderate, severe.

Anthony:
Yep.

Steve:
You're starting to talk about their level of how they're operating in community, about which services they need to access. Should we have a little look and see if we can break that down into some bite-size pieces?

Anthony:
Yeah. I think it's really important. And in preparation for this Steve, this is one of the things that we have found difficult trying to get this concept across. So I want to talk about mental illness, mental wellbeing in the terms of the person's function.

So mental illness; we've got a definition up there, it's about all those things, biological, psychological, emotional that impact upon us negatively being able to function in our normal day-to-day lives. It's the loss of something, it's the loss of function. On the other end, what we have is mental wellbeing. Now there's an Australian definition and the Australian definition is talking about the absence of mental illness. I find that a bit difficult in saying what's mental wellbeing is not being unwell. What mental wellbeing is, is being able to be connected with your community, to have some meaningful occupation or activity in life, it's being able to live your life to the fullest in a happy state. That's mental wellbeing. It's about functioning at that level.

Steve:
So rather than being too ends of the same spectrum, they are almost mutually exclusive but can relate and impact on each other. That makes sense.

Anthony:
So Steve we have mental illness, we have mental wellbeing, we have poor function and good function.

Steve:
Okay. So, maybe this helps describe that so that we can have the population of Australia being on the green arrow along the bottom, 20 per cent of that population have a form of mental ill health.

Anthony:
Yep.

Steve:
But at any point in time people could be living optimally and be well.

Anthony:
Yes.

Steve:
They could be living optimally and actually have an illness, diagnosable or a significant distress.

Anthony:
And that's a difficult concept for people to deal with. We have grown up as we have been coming more accepting of mental health problems in the community, for that cohort of people, that sector of people, people like Dr Geoff Gallop, the ex-Premier of Western Australia, who came out and talked about his depression. People historically which we know had a mental illness, be it Winston Churchill, who have talked about being and we know had a mental illness, but they function at an optimal level but lived with a mental illness.

Steve:
Absolutely. So they would be at the top end of that.

Anthony:
Yep, yep.

Steve:
So should we have a look at some examples of people that we've had the pleasure of knowing and working with over our career, to try and help inform this picture a bit further.

Anthony:
So, these are obviously de-identified, but I'd like to talk about a gentleman who I had the privilege of knowing very early in my career when I worked in a small country town of Western Australia, Bridgetown. We will call him Gary. This would be in the late 80s. Gary was a gentleman in his 60s at that time who had a diagnosis of schizophrenia and as you can imagine a gentleman of that age, 35 years ago or thereabouts, that treatment was probably not very sophisticated in his early years as his illness developed. Gary lived with a blood relative, I think it was his cousin, in a house in Bridgetown and his blood relative had bipolar disorder, similar age.

Now the two of them lived quite successfully in their home and to the outside world they seemed eccentric. To the person driving past the house it seemed chaotic. Now where they received their supports from was the local Silver Chain nurse. The local Silver Chain nurse didn't go there to bathe them or wash them or anything else like that, went in to check that things were okay, that they were functioning. They would cook their own meals, simple as it would be, and clean the house to an okay level. She was a constant, the Silver Chain nurse, as was the community.

The community knew when Gary was unwell and there was a very simple measure, and I learned a lot from this, was about what is a sign when a person is becoming unwell. His sign was he would go to every shop in Bridgetown, whether it was the butcher, whether it was the greengrocer, whether it was the baker, asking to buy a newspaper. And so the community then knew that he was becoming unwell, there was something going on in his thoughts, they would contact the Silver Chain nurse.

Steve:
What would she do?

Anthony:
Importantly, Gary trusted her. There was a relationship over a period of time and she'd say come on, lets go up to the hospital, and she would ring the GP, the GP would review him maybe change the medication, maybe pop him in hospital for a few days as a bit of respite and just to be able to settle him down. And it was all done within that community. In the four years that I lived in Bridgetown not once did he have to go to a specialist psychiatric service, let alone inpatient admission.

Steve:
Wow. So you have got somebody with a serious mental illness operating at an optimal level, supported by the community?

Anthony:
Yep.

Steve:
So on this matrix, we would place him up in this top left quadrant.

Anthony:
Yep. He had a serious mental illness and was functioning quite successfully.

Steve:
With minimal support.

Anthony:
With minimal support.

Steve:
And appropriate support. Okay, I'm reminded of Andy who I knew in Bristol in the UK. Andy was African-Caribbean background. I had the pleasure and experience of working with Andy for about 10 years.

Andy had schizophrenia as well and had probably been living with schizophrenia for 10 years without being diagnosed before he came to the attention of the services. Andy lived in inner city Bristol and it was a time of race riots. It was a very oppressed area. He lived with a brother who also had schizophrenia and we don't know much about his family background.

Andy had a very rare form of schizophrenia. He had tactile hallucinations, so he felt sensations rather than hearing voices or seeing things and they were incredibly distressing. For 10 years he lived with them sub-optimally. He became very distressed and at a point in time he felt the urge to set fire to the flat that he and his brother lived in and erased it to the ground essentially. Because he didn't have a mental health history or contact with services, he was arrested. He went to prison on remand and that's when he came into contact with services, he was identified as being very unwell.

For 10 years we got to know Andy. Andy was very suspicious of mental health services, or the system, it was an institution, it was a forensic institution. The majority of staff were white staff and he identified very strongly with his African heritage. Through building trust we were able to identify that using that African heritage and that African identity, he was asking in his words to see his witch doctor. We were able to bring in alternative therapies and alternative ways to understand his illness and he started to describe his sensations, and we were able to treat them with different medications to the different sensations that he was experiencing.

He also loved animals and there wasn't anything he didn't know about David Attenborough documentary, but also pigeons, and the interesting thing about pigeons in the UK in particular is pigeon fancying is a very white working class hobby and Andy being very black African-Caribbean identity, with a suspicion of white culture, we were able to use the pigeon fancying aspect and introduce him into the community to pigeon fancying clubs and him to build up relationships and trust with a segment of the community that he had never had a meaningful relationship with.

Anthony:
Steve, one of the things I am really interested in that story, which is very, very powerful, is that you had a conversation going on with Andy for a number of years and piece by piece that trust developed.

Steve:
Yeah.

Anthony:
There was a lot of listening there and what I'm hearing is there was a lot of working together to work out a recovery plan basically which you would not find in a text book.

Steve:
No, and that listening and that conversation was not just with clinicians, that was within the system if that makes sense. That was with the courts, it was with the judges, it was getting this disposal through a mental health system rather than through a court system, it was having a conversation with the wider community saying this guy is interested in something that you're interested in and getting them together. It was a really ... a privileged experience to be part of. Absolutely.

Anthony:
So, let's put Andy in this matrix. Where would he fit Steve?

Steve:
He started off very firmly in that bottom left hand corner and I think with support he moved up to where your blue block is up there, optimum wellbeing. When I left the UK, that would have been about 20 years, he was living in the community under supervision but he was doing well.

Anthony:
Okay, that is a wonderful story.

It reminds me also in terms of a person not functioning of a much different scenario. I am going to talk about a young girl and we will call her Amy. This young girl in fact is a story which again it was a privilege to be working in a service where we could provide some support for. It was in an early intervention service, so it meant that we could get in early for young people, and the service would sometimes see a young person who in fact did have quite a severe mental illness and other times a young person who was just not functioning and Amy was one of those.

So Amy was about 15 or 16, she lived with her mother and her younger brother. Her mother had a chronic health condition, so Amy was worried about her mother. She was also trying in some ways to bring up her younger brother and was worried about him. Her father, she had some connection with her father, he lived separate to that family home.

She, with all her worries, was getting quite distressed at school, she began to fail at school. That fed on her worries. Her distress led to some self-harm. The school made the referral to the service and we had a young woman who was full of worries, was not functioning at school and had begun to self-harm. She had some signs and symptoms of mental health problems. What the case manager did, and this is the conversation again, was build up a trusting relationship and began to connect her into normal parts of life, so worked with her mum, her dad, worked with the school extensively, connected the young person to a youth service and worked a lot with the general practitioner. So with all those connections was about to get a system of care around this young person.

At one point she got quite distressed and there was a brief admission to a mental health unit. Interestingly what this did for Amy was her to understand that in fact she was not mentally unwell and that she was distressed and that her pathway was better to be about improving her function. I have got a really great outcome to this. She just engaged so well with her case manager that she got through school, and she was a very bright girl.

Once she got through school she got to university, a four year degree in the allied health profession, she is now a qualified allied health professional assisting other people in her community.

Steve:
That is fantastic. And a number of things resonate from that story. One, our role in supplying psych services into the emergency department system that I think we see Amy's every day, presenting to emergency departments in crisis, looking for mental health support, and the system is designed or attracts people in crisis when that might not be the right environment and Amy's story demonstrates that the recovery is certainly going right on the spectrum rather than going left into mental illness.

The other is about that hope and recovery and that we need to hold that front and centre when people are presenting in crisis, that there is hope and there is recovery. And thirdly, the impact of being a carer. She was a 15 or16-year-old carer for a younger sibling and a mother with a chronic illness. Whether she identified that or not is those stressors.

Anthony:
There is one other thing too Steve that I am reminded of is that people actually want to be well.

Steve:
Yes.

Anthony:
And then when a person is not functioning well, and for Amy there was the realisation that she wanted to be well and that was a strong motivation. And my experience is, is that people want to function and want to be well.

Steve:
Yes. And I think we will look at that in a minute about turning from those deficits, those negatives into something positive.

Anthony:
Amy was clearly there and is clearly now in the top ...

Steve:
In the top right. Yep. And if we could work the animation we would have made that.

Anthony:
But we are not that clever.

Steve:
No. So let's recap on some of the things that we have discussed in those real life examples. We have identified a number of factors with all three people that were pushing them to the left of the spectrum, pushing them into illness. We looked at biological aspects of some family history, both Andy and Gary. I am not going to talk about biochemical and brain function, but there were some biological things happening.

Psychologically, Amy she was a young carer, early life, trauma, the ongoing effects of being a carer. Certainly with Andy there would have been life trauma there, and then the social aspect, living in poverty, living in an oppressive environment. Not having access to some of the qualities of life that you and I might take for granted and appreciate, and maybe exposure to alcohol and drugs.

Anthony:
And with all those causal factors, if you want to call those, the biological, the psychological and the social, there is a whole story around those because those manifestations of mental illness can come from a whole range of reasons. They can be here and now, could be a trigger. A person may have been a victim of some type of major trauma. We know that from soldiers, particularly in post traumatic stress we see that a lot and there are more and more services going for that, into the population. It might also have been something which is ongoing, and a reminder particularly for young people, it also occurs for us adults as well, is the experienced of bullying which can be ongoing and ongoing and ongoing.

So we have perpetuating factors, we can have a precipitating factor, we can also have a factor we call predisposing factors and these are just words, but the concept behind that, has it been something that has been present for a long, long time. So, it may all be a predisposing factor could be the persons' genetic makeup. It could be that they have lived in abject poverty for a long time. So, none of those are causal but they are all influences, chronic or here and now.

Steve:
So, what we do in mental health or what we try to do in mental health in conversation and partnership with the consumer, with a carer, is to understand the impact of those on the individual and their support network and turn those deficits into strengths.

Anthony:
Strengths. Yep. So we can use exactly the same framework Steve and from a strengths model. Alright, and so we can be having a look at, if you look at the biological, well from a strengths model lets assist a person with a healthy diet, exercise, healthy lifestyle. We know those factors have a positive impact upon mental illness.

Steve:
And occasionally medication will be appropriate.

Anthony:
Of course. Absolutely. That is part of the picture. Not the first part but is often a significant part of the picture, and for others it is a small part of the picture.

Steve:
Absolutely, yeah.

Anthony:
The psychological, building resilience, building skills. We know there are a number of very well researched evidence based ways of assisting people from psychology services.

We also know from a social aspect, things like stable housing, things like having a meaningful life and recreation or occupation can be really important. And again, we can be thinking about those ongoing factors. And I talked about, there is one example before about bullying. So, from a treatment perspective if that is in the foreground for a person, we can actually assist about how to overcome either through the person building some resilience, but probably more importantly how to actually use the situation they are in to deal with that bullying.

Steve:
Yep, build some skills.

Anthony:
Build some skills.

Steve:
So, my mind listening to that is starting to bring me to how do we start that conversation with people presenting to a service and manage the expectations. So clearly people in crisis wanting to come to mental health services have expectations that we will be able to unpick, unravel the biological, psychological, social determinants of health and their real health and their distress, and put into place measures. Sometimes those expectations are quite high, quite quickly and that is a challenge isn't it.

Anthony:
Look the expectations understandably are very high. We talked about the incidents, we talked about the complexity and we live in a modern rich society, so it is understandable to have high expectations.

I just want to pause a little bit Steve just for ... We all reflect though that we are very fortunate to be living in this modern world, but in terms of the system for mental health, it is a new system. Just briefly, a bit of a historical journey for mental illness in the Western world, because that is where we are, we know ancient Greece saw mental illness as a medical problem and their physicians of the day treated that mental illness.

The next significant change was the middle ages in Europe, and their mental illness was seeing people who were demonised or affected by witchcraft, and that was the prevailing thought of mental illness, that it was somehow a person was bad because of demons and often those people were institutionalised in appalling conditions.

We come to the 20th century and it becomes a ... well even probably from the age of enlightenment from the 1800s, is it becomes seen as a medical condition again. What is interesting though is that, well not even was medicine rudimentary but people were still institutionalised and so the treatment for people with a mental illness was still inside four walls and closed asylums.

Steve:
Yep, and I understand antidepressants and antipsychotics were not even invented until the 50s and 60s?

Anthony:
No. The 60s was really important. We had some new medications, really importantly became a human rights perspective and with that the voice of people, their own lived experience which is I think one of the important things we are trying to talk about today is how important that is, is that came to the fore. But the 60s still had, even though there was human rights and there were better conditions in the asylums, people were still institutionalised.

Now I started my career working in mental health in 1990. 1993 was Australia's first national mental health plan. That is only 26 years ago. Now that first national mental health plan said lets deinstitutionalise mental health treatment in Australia. Only 26 years ago, Steve.

Steve:
And I think, to really put that in perspective, West Coast Eagles won the first flag in 1992 and the second one in 1994 so those should stick in people's minds.

Anthony:
The other thing about the newness of this, is that we are dealing with the most complicated organ in the body, and the brain controls our thoughts, our emotions, our cognitions, our movements, our memory. I am astounded by the complexity of the brain and no wonder it is still the least understood. We now know there are 90 billion neurons, cells in the brain, and we know that each neuron has up to 1000 connections. So we are talking trillions of connections that the chemicals and the electric impulses pass through to control our emotions, functions, memory etcetera. This is new territory.

Steve:
It is, and the public have expectations and our community have expectations that they can present to a service and we will understand what is going on inside that brain and ...

Anthony:
That's exactly right.

Steve:
... balance all their social, psychological and biological factors. And why shouldn't they expect it.

Anthony:
Yes, exactly.

Steve:
Let's move on and start looking at the system that we have now.

Anthony:
Yep.

Steve:
And how do we meet expectations with the mental health services that we have? I am going to go out on a limb and say that our mental health service is designed to meet those expectations, and I know we get a lot of frustration from consumers, but I will explain a little bit more. There is a need for intensive care services, people in crisis, we have those. There is a need and a desire and an expectation for rapid response at times of crisis. We have 7 day a week, 16 hour day community services. There is a need for early intervention to prevent full blown illness and our services provide that. And there is a need for long-term supportive care where people need that. The service is designed to meet those expectations, I am not so confident that it is designed to manage those expectations.

Anthony:
Steve, yeah we have talked about this a lot, can the system manage those expectations, can we meet those expectations. I am reminded about how important communicating for the general public or even for each individual person we see, which includes staff members, is about all those components of the system and how to get the right person in the right place at the right time.

Steve:
Any other service industry looks to its customers and listens to its customers, and when customers have poor experience that service entry is flexible to change to meet those expectations and that experience, to indicate that experience. That is why I think it's not mature enough to manage those expectations, it's inflexible at present, and we need to look internally and externally about can we adapt our mental health services to flex to the changing need of the community.

Anthony:
And we need to keep the conversation with the community going Steve, because there is still the past experience of stigma, and that's real. Talking to consumers, as I have the privilege to do on a regular basis, that is a real experience in our community still, and with stigma becomes the reluctance to share experience, a reluctance to seek assistance early because of the shame of having a mental illness.

Steve:
And we saw that at the very beginning of this presentation about the language that is used in everyday parlance is stigmatising. So, what can we do to look forward? Yeah.

Anthony:
So, a way forward. We really believe that there are three significant components for a way forward, and the most important is the conversation, the participation, the listening to, the joint care planning with consumers and carers.

Steve, you talked about any other industry would look to their customers, certainly in mental health it is about the person with the lived experience and their carer family. In the end, where the most powerful changes come is in the person's home and community. It is not in your office or my office. So we are compelled to be working closely at a planning level, at a business level and as importantly at a treatment level.

Steve:
Yep, and I would suggest also reviewing that as well plus consumers and carers to review our services.

Anthony:
Absolutely, absolutely. So, there is far more space there and it requires the system to put the resources behind that to enable us to have those proper, meaningful conversations. And I know that is a resource answer to it, but it is really important. At the moment we are not always resourced to have the supports for consumers and carers as we would like to be able to do.

Steve:
But we have got no shortage of consumers and carers.

Anthony:
That's right.

Steve:
We have, currently our service has 1,300 active consumers. That is a loud voice.

Anthony:
That is a loud voice. The other thing which this is a bit of bureaucratic aspect, however it is worthwhile saying, is that the mental health system is constantly under review. Constantly. And two examples are Western Australia is going through another review and it is called the review of the clinical governance of acute mental health services and there will be opportunities for consumers and carers to have input into that, and the more input they have the better. And Australia wide there is the Federal Government has announced yet another review called the Productivity Commission.

What is really hopeful about that review, to me, is it is about through the lens of people having meaningful place in community rather than through the lens of the governance of it. So that is really useful. Again, there will be opportunities for that. The other thing is that what we try and do, and we know we don't succeed in all cases, but we certainly have got a workforce that tries to do this, is take responsibility as our part of the system to act now.

Steve:
Yeah. We are funded by the taxpayer, we are providing a service to the taxpayer and the community, we have an absolute responsibility to use our resources as best as possible.

So I am just going to end, if you would allow us to indulge ourselves, just to say what we do in Peel and Rockingham Kwinana area, in this area taking this seriously, is we strongly believe in working in partnership. We provide our early episode psychosis in true partnership with them. We are in true partnership with Mind Australia providing the step up/step down service, a non-government organisation running that service and we put the clinical input in there. We work with HealthyMinds and Lifeline, supported today. Three sixty health provides the Alive programme which is the suicide prevention programme that is co-located in our community mental health services allowing us to be able to identify the right person to the right service, accessing different parts of that continuum if

you like. And we work with 30 different organisations doing suicide post prevention and prevention work, supporting people after suicide and obviously preventing suicide. So there are a number of things that we do and working with consumers and carers at every part of our governance structured and our peak meetings, so yeah I think we are doing something with what we've got, but there is still a lot more to do.

Anthony:
And it's a foundation stone, we understand we need to keep doing that.

Steve:
So in conversation we have covered a lot of material, would you mind summing up some take-home messages?

Anthony:
Yep. So, this is I guess we tried to bring some take-home messages for everybody today and one of the things that we wanted to reiterate, it's okay not to know. It is complex – mental health is complex. Associated with that, it is okay to ask. It is really important to have those conversations and ask, and that can be with a whole range of people. It is your general practitioner, it is your ED physician if you are in the Emergency Department, it is the school teacher, it is your mum, your dad, your partner. It is okay to ask because keeping those conversations silent and separate is not going to be a way forward.

We also know, and we went through this before with those two little diagrams that we had about strengths and also about deficits, is there are known risk factors and those risk factors are a whole range of things, biological, psychological, social. We know there are protective factors when you turn them on the side. What is important in that is that if I was a clinician I have my theoretical understanding of them, of what are risk factors and what are protective factors. The key to it is that who I am working with and their family have the lived experience of those risk factors and those protective factors. We must work together because this is a case of the whole is more than the sum of the parts.

And so the conversation, the trust, the relationship, the listening, the joined up care plan for each person is the critical thing. Today the topic was an opening conversation, and the opening conversation is actually that the consumer and the carer, lived experience along with the clinician will come up with a way forward.

Steve:
Thank you. Thank you.

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