2019 Submission - Royal Commission into Victoria's Mental Health System

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What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?

"Tell the psychiatric world to at least be coherent. Is it an illness we have? A disease? A disorder? A disability? Psychologists keep telling us there is nothing fundamentally wrong with us, that we are not broken. Then the outranking psychiatrist says no, there is definitely something wrong with you and here is the tablets that will fix you. Psychiatry has tried and tried for decades to say there is an organic basis for mental health problems, and it has failed and needs to stop pretending it succeeded. Depression is caused by a lack of serotonin...? that is a well proven myth that helped sell an obscene amount of medications. Maybe there will be a cause identified one day, but until that is proven robustly, the continued clinging on to and reference of old ideas is harmful. The British NHS campaign of having a mental illness is like having a broken leg (or whatever it was) was not helpful though well intentioned. Having a mental illness is not like having a broken leg... But nor is what we are experiencing 'all in our head' Nor does having a mental health illness mean that you are nuts"

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

"That there is a well developed public mental health service and infrastructure, that is free and accessible in urban areas is obviously a good thing. That such service has to deal with the most acute and dysfunctional of us means it seems overwhelmed. The private system seems like it is there for rich people to get psychotherapy and talk about how they are feeling, while the most affected and burdened by disease are left to navigate an overburdened and essentially dysfunctional system. If you are poor it is easy to feel like you have to wait until you are severely unwell before you can get help. From my experience there is no easy access point unless you are in a crisis; there is no group therapy and little to no community engagement. I feel like the public system is battling to not fall apart itself, that its crisis reflects on us, that it will be there for us if we too are in crisis. But if you aren't then the waiting times and lack of access to qualified staff is an issue."

What is already working well and what can be done better to prevent suicide?

"Though from what i hear from other patients, stigma has improved, there needs to be continued efforts to eliminate the idea that suicide attempts and or self harm is a burden on the system. If people in need of care fear that they will be judged by accessing care there is a problem. But in my recent experience, that there is a free service nearby easily accessible in a crisis situation is incredibly valuable and needs to be defended at all costs. Remind people that are suicidal that they evidently don't want to do it, because they are saying it (if we really wanted to do it we wouldn't be saying anything. Let us know that it is not so foreign to the modern human condition to contemplate it. Reduce the taboo nature of the whole subject. "

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

"Cost. Waiting times. Cost. ... and Cost. There is a fundamental flaw in the current system- that the sickest patients are forced to rely on the public system. The public system is under-resourced. The sickest patients are left to be 'treated' by psychiatric registrars while they learn their qualifications. Then once they qualify they leave the public system to make loads more money in the private sector. In my experience, registrars only do 6 month rotations, with NO HANDOVER period. So the months of transition are weak points. In addition the use of overseas trained practitioners results in vastly differing approaches and skill levels, not to mention levels of english. I have absolutely nothing against anyone from any country (having worked in the health sector in many different countries) however having to ultimately mime a new (and more severe) suicide ideation is not ideal... Having been treated in Europe, i also feel that the fees charged by practitioners in Australia is excessive. Try finding the cash to see a private practitioner whilst on centrelink... In my experience the public system does not offer specialised treatment for something as essential as trauma (!). To try and access more specialised treatment is very difficult unless you are rich. That fees are not regulated, that we have to try and negotiate a price before or after treatment is excruciating (particularly when we are unwell) and means many of us that need further care cannot access it. Why is it that a nurse, social worker, OT or psychologist that i access through the public system and detain me (albeit a temporary restraining order) whilst if i was to say the same thing to a private psychologist they cannot detain me? Whilst the lack of staff in a private clinic may partly explain this, and ultimately the private practitioner can call the cops anyway, it does fundamentally change the interaction. If we fear that we may not be allowed to leave after we go for a consultation (and be held by the very people we are supposed to trust...) there is a problem, and we are naturally going to be defensive and guarded in the public system. And why is it that when Australian's in the top fifth income bracket see a psychiatrist they see one on average twice as many times as an Australian in the bottom fifth (and this includes registrars, not the qualified psychiatrists that work in the private system) even though the bottom fifth receive far more prescriptions for antipsychotics and other indicators of increased burden for example... In short- the people that most need high quality care can't access it."

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

"Socio-economic status perhaps? But not because you are necessarily going to have worse mental health if you are poor (though a few dollars sure does help), but you are definitely going to be a lot poorer if you have mental health problems. A poorer community will therefore have more people with acute needs and any service provision will have to bear this burden. Plus it is my impression that qualified mental health professionals earning the kind of money they can don't want to live (or work) in a poor area. But having said that that many many people are forced to go on centrelink due to mental health problems means that not only do they (we) face the stigma of mental health (as in you may not look sick) but also that of government support. The added stress of trying to live on $250 a week whilst unwell is criminal. When simple acts like going out for a coffee to try and improve your socialisation is avoided because you can't afford it... there is a real problem. For most of last year I did not have phone credit (partly because i got a dog (who is undergoing psychiatric assistance training (at my expense of course)) to try and help me. How are you supposed to achieve a sense of self worth when you face the stigma of being a burden to society because you are on the dole?? What needs to be done? Regulate the industry, end the massive MASSIVE gap between public and private services and stop psychiatrists getting so rich

off the suffering of others. (good luck with that) Increase centrelink (good luck with that too) Rural access has to be an issue. I have lived in rural Australia for a lot of my life and i cannot imagine achieving the same outcomes i currently have (I now live in the city and can walk to my local mental health service) if i was still there."

What are the needs of family members and carers and what can be done better to support them?
Reliable information. Access to professionals to answer their many questions (or the supply of quality information that would avoid the need for questions). Suggestions for how they can help their loved ones.

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
"Create a stimulating well supervised environment with management that focuses on recovery. In my experience i have seen too many well intentioned and competent staff in the public system who seem highly unstimulated and lost in a system that appears to have little expectation for improvement let alone recovery. Regulate the private system, so that so many staff are not lost to build their empires or buy Porsches."

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?
I have no idea... and i have been in the system for 18 months Sell drugs? Beg on the street? I have no idea.

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
Reduce the dominance of psychiatry (psychopharmacology). Reduce the divide between the public and private systems. Make talking therapies more accessible to poor people. Acknowledge the role trauma may have in many diagnoses and provide access adequate trauma centred care for everyone

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
"Aside from abolishing the private sector entirely... Make the private sector shoulder more of the burden. Make the private sector take a role in the education of at least some of the many that will end up there. Stop short rotations for registrars that have no visible supervision. Start regulating things now. It is the wild west, but they wear shiny suits, kick you out after 50 mins and drive fast cars instead of horses. Advocate for standardised treatment guidelines, particularly for medication management, that are somewhat enforceable, or just like other areas of medicine. First-line treatment for x is y (if not, explain why you didn't...). Psychiatrists can and do whatever they want, claim to be evidence based, but then ultimately say it is an art..."

Is there anything else you would like to share with the Royal Commission?
"Aside from the questions raised in previous answers given (that revolve around the glaring differences between access to care for poor versus rich people) Why is it that over half of admissions to inpatient care is involuntary? Why is this not reported regularly by the chief

psychiatrist? Noting that this does not include those admissions (like my last one) where after refusing i was given the option of going the easy way or the hard way, with the main argument that it is easier to get out if you go in voluntarily (the easy way). I have been admitted in other services overseas, and would gladly go back when required, because i felt like it was helping. Inpatient care has to be more than just supervision.   Other points for consideration -to get a psychiatric assistance dog requires substantial money from us patients, and the organisation that facilitates it gets no government funding. Having an assistance animal could meant the difference between re-entering society and potentially employment for some of us, and can mean that we are not stuck at home in a medication induced half coma. Having the dog saves the government money. -Informed consent/decisions have to be more than just the offering of two options, though that is what we are routinely offered in the public system. To be only offered two medications for a condition that can have multiple treatment approaches is simply coercion, because one usually appears superior to the other.   -Psychoeducation would appear to be an virtually unheard of concept in the public mental health system. If we as patients are left to google our new diagnoses there is a real problem.   -The Australian health system relies to heavily on its excellent emergency care system. This also seems to have affected the mental health system, where as long as the ultimate disaster is averted treatment is somehow seen as a success. Having applied for a peer support worker role, and having some former colleagues that work in the system, the reliance on short term treatment goals or prevention (roles whose aim is simply to try and prevent readmission within x days of discharge etc) means that it feels like the system is trying to achieve a positive outcome by default, that wellness could at best be a useful byproduct of preventing inpatient admission. Though of course it may not be. People that could greatly benefit from more acute care may simply avoid it, to their and their families and potentially societies detriment. It feels as if it is just a series of loosely connected services trying to tick boxes instead of a coordinated response to a health burden whose aim is to achieve wellness. Thankyou and good luck. "