Your contribution

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1. What are your suggestions to improve the Victorian community’s understanding of mental illness and reduce stigma and discrimination?

Many campaigns address stigma around mental illness. However, a greater understanding of the risk and protective factors to mental health; and factors which exacerbate existing mental illness are also important to educate communities about. Mental health should not be discussed as if in a vacuum, for example, that people simply experience ‘anxiety’ or ‘depression’. While recovery principles are better understood in clinical and (some) health promotion settings, I believe recovery from traumatic experiences could be better incorporated in campaign messaging to empower people beyond help seeking, into helping themselves.

There needs to be greater community awareness about the impacts of trauma and lived experiences of discrimination/violence/isolation etc. In particular, how trauma manifests and can arise episodically over people’s lives and impact physical health. For example, there could be layperson information provided about PTSD/ CPTSD symptoms and the multiple ways to address symptoms and support emotional and physical recovery.

Mental health education campaigns could target victims of crime (such as family violence, hate crime or institutional abuse) to highlight vulnerabilities to people's wellbeing after traumatic experiences. For example, by bringing awareness to how people’s thoughts and behaviour might change after significant traumatic and shocking events. Campaigns could target whole communities at higher risk of discrimination or violence, communities impacted by natural or climate change induced disasters as well as people who think they may be experiencing trauma/grief related distress symptoms.

Please refer to my personal story below for expansion on the Royal Commission questions and themes. This section includes distressing content.

2. **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.**

To answer these questions, I will relay relevant parts of my own childhood circumstances and life story. I believe it serves as a case study as to how services could support vulnerable young people better, and how the experience of all services can be improved to recognise risk and protective factors to mental health and overall health and safety.

I am now a [redacted]-(man in my forties), but my experience as a carer of a mother with mental illness during my formative years has shaped my personal (and to an extent professional) views of existing needs in the mental health, health and human services systems broadly.

My history as a carer sits within [redacted] (an interstate) context, where I lived my childhood three hours out of [redacted] a large capital city). However, I believe key issues and themes remain relevant to this inquiry in Victoria. I have lived in Victoria since 2002 and accessed private psychological support services here to maintain health, wellbeing and seek professional supervision. I have also worked in family violence, homelessness, disability, aged care, mental health, in non-profit administration, direct service, policy and research after achieving a [redacted] (human services) qualification in my mid-thirties.

I am a transgender man. I transitioned medically and socially from female to male upon graduation [redacted] (from a degree in a human services subject). I bring to this submission the experience of a young queer carer - and later adult survivor - who had faced family violence, family mental illness and who lived in a rural area. I believe themes of my experience are most likely shared among some young carers/ and vulnerable queer youth in rural Victoria today.

Background

My mother experienced what I believe now to have been complex PTSD (due in part to institutional care experiences, and supporting her mother who drank and experienced depression); she also had anorexia and bulimia, hoarded, and experienced multiple other forms of undiagnosed mental ill health. This was alongside distress caused by violence towards her by my father that I witnessed and had also been victim to for 15 years. The violence in my parent's marriage had occurred since the birth of my older sister. My mother had poor physical health and regular injuries caused by my father's attacks. My brother too was a target of my father's violence resulting in many physical injury's including a broken nose during a severe incident.

Today my brother struggles with mental health/suicidal ideation, personal relationships and has had numerous diagnosis of ADHD, bi polar disorder, anxiety, depression and been on multiple pharmacological therapies. The latter in my view have done little to alleviate the inevitability of his graphic memories of childhood. Rather these approaches have accompanied less stability as much needed exploration of grief and sadness has been deferred by conversations about medication regimes, side effects and medication changes. (Most recently my brothers ill health, my need to support him - and thus myself - incurred on time I required to complete submissions to this Royal Commission, however an extension to undertake this work was not offered despite being sought. I found this both ironic and distressing). My sister still experiences extreme anxiety and depression which has resulted in several suicide attempts some years ago – she now manages her symptoms with a range of hobbies and exercise, however is mainly estranged from us.

In addition to family violence and witnessing the sexual assaults of my mother I experienced repeated incidents of childhood rape/sexual abuse from neighbours and church members. During these times and with this abuse unknown to others I simultaneously supported my mother with her life threatening mental ill health. My own vulnerability to further violence existed as a result of my home instability and neglect, and was a significant contributing factor to me being targeted as a child by perpetrators of sexual abuse looking for victims under the radar. Later in my late teens I was a victim of a significant gay bashing by four adults.

How to determine between 'madness', the impacts of adversity or defensive behaviours?

My mother's distress was incredibly difficult to navigate. Her own experiences of shameful acts of physical and psychological abuse in front of her own children obviously was no environment for mental health recovery and a driver of significant ill health in every sense of the word. For me as a child I was constantly trying to weigh up the difference between her 'mental illnesses' (anorexia/bulimia), responses to violence (anxiety, distress, uncontrollable anger); and later in my teen years, what I began to recognise as defensive behaviours against my father (acting hysterical and as unattractive as possible to put him off raping her).

Even at a young age I grew to understand knowing the difference between these behaviours was important to keeping us safe. I knew if she was consciously using strategies it was safer, unlike when she had fully fallen into a psychosis, trauma flashback or prolonged suicidal ideation. The latter in particular would mean she would seek out danger and risk – provoke my father and danger for all of us would increase. I knew 'caring for mum' included a need to try and figure out all of these things. I often wonder why if I was considering these subtle differences as a child, do mental health specialists and services not always explore the same nuances in people's behaviours?

The disjointed contact the family had with health services at the time meant the true extent of what was going on was significantly hidden. The only time my mother was treated for emotional distress, no screening for violence occurred. Typical of the time - perceptions of women went hand in hand with 'hormonal problems' and being 'prone to moods'. I remember sitting in the GP office next to her while she was prescribed sleeping tablets and anti-depressants knowing full well she may consider overdosing on them. I managed this risk by hiding her medications, on a few occasions I used them myself so I could sleep.

Where does mental health caring and caring for a loved one's trauma begin and end?

In terms of 'care responsibilities' there were things related to my mother's eating disorder and depression which I had to do specifically. These being trying to manage her medication, make food for her, clean the bathrooms (walls and floors) where she often made herself vomit, bring some order to the house which was crowded with 'stuff' and declutter, stay home from school to keep her company when she seemed at risk to herself. I attended to her emotional and sometimes physical injuries.

Similar to the overlaps between drivers and expression of my mother's illness, identifying where my own trauma symptoms and anxiety all meet has been a complex journey. This has created significant complexities for me to find appropriate services, or relate to public messaging about mental health. Considering the times in my life when I have felt most depressed, anxious and vulnerable – the idea of having a 'mental illness' - was never conducive to recovery or validating of my experiences. I benefitted most from people who validated the 'madness of my childhood circumstances' rather than focusing on a diagnosis for my mind.

Trauma histories need to be front and centre of mental health support service frameworks - as well as front and centre of a broad range of treatment and support models. I cannot stress enough the need to bring context to distress people are seeking support for.

This includes access to a full range of modalities which address PTSD and CPTSD responses in adults, children, young people and also the elderly. I note the elderly because for some people trauma never goes away, can arise when life becomes quieter/safer or in the case of people like my mother who spent time in institutions distress may accompany a prospect of less independence or admission to residential settings.

Government, mental health/health & human services, researchers, policy makers, health promotion professionals etc need to acknowledge the ways in which trauma drives poor mental health and to be able to identify these risks and drivers at every nexus of ALL service delivery that targets vulnerable families. This requires examination of how mental health support, early intervention and prevention is funded by and within multiple government departments. This will assist in better integrated 'whole family' work.

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

Homophobia drives poor mental health risk taking

Thinking back on my coming out process and exploring my sexuality, I recognise the feeling of relief learning a language for the ways I was 'different', which were beyond what I was taught by the church. Yet on the other hand it brought immense fear of discovery. Particularly because my father expressed hateful opinions about gay people. This added to hypervigilant behaviour and risk taking with other young people and intimate partners I had at the time.

Not fitting in - neither here nor there

As society grew more accepting of gay relationships I felt a loneliness of a different kind. I felt like an outcast in mainstream lesbian and gay communities due to my dysfunctional family background. I didn't feel I could live up to the 'cool', 'confident' gay people I started seeing in the media and in clubs. Many city queer people openly mocked rural areas, people at bars told me to 'leave', no one ever offered to visit and often called it 'a backwater'. As I had been bashed in the streets of my hometown I could barely argue the point.

These days (ironically) a lot of queer people ended up moving there, it's a fashionable area and I am priced out. I find natural environments very comforting and where I come from is surrounded by national park – if I could afford a place there now - I would move back to the bush in a heartbeat.

I think the transition for rural young lgbtq people who move to cities can be very difficult, particularly young carers who may stay in communities with high unemployment so they can care for a family member longer. They may have fewer financial resources and being part of the queer community - like any other - costs money. Being poor can create shame and exclusion in queer communities which can seem full of festivals, pricey dance parties and big personalities.

Shyness and a lack of confidence may increase drinking/using drugs to fit in which can be a terrible combination if you are homesick. Add the stigma of having a mother with severe mental illness and family violence and there seems few people around of a similar experience. I managed to meet other queer misfits growing up, though collectively we self-medicated. Some of these people died from drug overdoses and alcohol abuse. My best friend died from HIV related illness when I was 24, I cared for him too in tandem with his visiting remote rural family members. His death felt shattering.

For me back home opportunities to meet other young people in social groups was facilitated by a local youth service for a time. This was helpful but transport getting there was hard. Not all the other young people in the group were LGBT but none of them felt like they 'fitted in'. Places to go to meet other queer people that didn't revolve around drinking/drugs was another helpful factor. Just getting to a gay friendly bookshop, coffee shop that had gay owners was a godsend. When I could get to these places I felt 'normal', included and I could get away with just sitting there buying one coffee over many hours and feel like somebody.

Rural areas and being queer in place

I think rural areas are changing today and more young people can stay if they have solid family foundations which is great. But I know other older 'queer rural refugees' who miss home and carry sadness about the lack of options or safety in earlier times. In regards to care experiences – I have met other queer adults who had to return to communities where conservative views remain and they have been expected by married siblings with families to care for the very parents who forced them out of their childhood homes.

Disconnection to places of origin can have a massive impact on mental health. While I never had a safe community or family back home – I had the natural environment which was my refuge. The grief around loss of place is not resolvable within a mental health system. I manage my sadness by camping far away in national parks. I find absolute balance in these places. If I came across a mass of money I would set up an organisation to get distressed queer people (particularly city-based folks of rural origins) into the bush, camping and sitting with nature. I am biased because for me it has been by far the most significant healing force in my life.

I would greatly welcome options to promote mental health and respond to poor mental health that include outdoor recreational therapies with people who have experienced trauma. Sports, exercise too are of benefit but for lgbtiq people, but these opportunities need to exist where facilities are not gendered spaces. There is little examination on how involvement in these sorts of programs/activities for people with mental illness or trauma reduce their need for mental health services. Please. Researchers take note.

4. 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?

Pathologising of queer people with trauma

It is important to make clear the impacts of both current and historical pathologisation of LGBTQ people in the mental health system and the DSM. As a transgender man I will not speak on behalf of all LGBTQ communities. However, I will say the medicalised model around gender transition services, prior and current categorisations of sexuality and gender in the DSM, clinical psychiatric emphasis within mental health services and the lack of safety in the public mental health (and health) systems played a significant role in me actively avoiding contact with the public mental health system at all costs.

While earning a minimum wage I preferred to pay private practitioners in instalments and manage trauma I was processing via ongoing financial debt. This often meant going without food, or having to negotiate bill payment plans, or not using heating in my house. It meant choosing between a dentist or being able to keep well enough to earn a wage in the first place. Psychiatric gatekeeping views of transgender identities created a fear my trauma would be further pathologized thus limiting access to supported gender transition.

The private practitioners I have accessed although costly, have used a range of modalities including emotion focussed practices, meditation, alongside arts therapies and managed programs to involve me in physical activities. The goal with all of these efforts have been to address trauma, experiences of sexual and physical violence, grief associated with caring for my mother and missing out on a normal childhood. This support made my gender transition possible *in spite* of my adversities. It ultimately supported me to come out later in life and kept me alive so I can be where I am now in a professional role.

5. What are the needs of family members and carers and what can be done better to support them?

My needs as a young carer

As a young person my circumstances took a social toll and a toll on my education.

The school I attended was a religious school associated (with a well-financed and reclusive church) [redacted] -that my family attended. Not once did the school raise alarm regarding absence from classes, however it did acknowledge in my yearly reports that my leave ‘due to sickness was significant’.

In regards to young carers or carers experiencing FV: Witnessing violence, and having little support holding my mother during her many suicide attempts impacted me greatly. It particularly caught up with me in my late teens after my father left the home and my mother settled with another partner. She was safer, began to improve and her new partner supported her during more of her ups and depressive downs. However, my own trauma symptoms finally found the space to emerge once the responsibilities lifted. In addition, by the time we were safe I had missed so much school I left early. Unsupported, traumatised and yet now ‘free’, I left home. I floated in and out of homelessness and during attempts to do further study my own mental health worsened as I tried to process my prior circumstances, dramatically prolonging the time it took to complete courses.

As I mentioned above, for some young carers with complex needs such as family violence and who may be navigating issues such as sexual/gender identity, or self-medicating with drugs and alcohol, getting to ‘the beginning of the rest of their lives’ can take decades. ***There needs to be a longitudinal lens on how these young people may need services across their lifetimes and into adulthood.***

Family violence services need to be aware of care relationship dynamics

I can imagine many young carers trying to both 'care' for, and keep a family member/s safe in violent households find accessing family violence services difficult. Services do not necessarily understand mental illness; or the multiple pressures on a care relationship irrespective of violence; that young people may be a carer and/or part of a safety plan; that violence has been a barrier to accessing mental health services; that a young carer may be afraid of removal by the state due to the parent's illness with the latter possibly leaving a sick parent on their own living in dangerous situations.

Identify emotional crisis among carers and prior carers/caring family members

There is a significant need for mental health services for carers, and to identify 'client carers'. Meaning mental health service users should be screened for their caring role/s. I believe many young carers from volatile and vulnerable families need comprehensive trauma informed counselling (multiple modalities – including body focused/somatic work/art therapies - not just talk therapies/or pharmacological) alongside case management, housing support, financial support and support getting back into education.

I believe too, family inclusive mental health and wellbeing services are vital, particularly those which are for community/by community and understand the needs of marginalised carer cohorts (ATSI, LGBTIQ etc) and which address ages/life stages. Services need to identify mental ill health risks and a range of vulnerabilities among ALL family members.

Services should offer case management for multiple family members where appropriate to address a range of risk and protective factors to their health (physical/mental) and safety. This can prevent things getting as bad as my circumstances did when I was younger, and identify issues which both *result* from and *cause* poor mental health in families.

While the issue of abuse by family members who say they are 'carers' is a real issue and demands attention, the discussion of mental illness and family violence has revolved largely around 'abusive carers'. The reality of how family violence occurring outside care relationships impacts people is also important to recognise and respond to.

Interestingly during my (working life) [redacted] I have supported people in care relationships where family violence is present. I have heard caring family members describe abusive partners who threatened the person they care for, deliberately disrupted contact with people they support (such as elderly parents), or tried to evict the person they care for from the home. There are many ways family violence can impact care relationships and the safety and support these may otherwise provide. In addition, there are ramifications for children who care for adults with mental illness who may become volatile (such as what I experienced), or risks to frail elderly parents supporting adult children with mental health issues and/or heavy drug use which may result in violent responses to distress.

6. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

In a response to the Victorian Parliamentary Economic, Education, Jobs and Skills Committee inquiry into Career Advice Activities in Victorian Schools Carers Victoria identified a range of ways in which young people's education is impacted by their caring roles. [1]

This work highlighted the 2017 report by the Australian Institute of Family Studies (AIFS) noting disadvantage

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[1] https://www.carersvictoria.org.au/media/1225/january-2018-submission_economic_education_jobs_skills_committee_carersvic-finalv.pdf

among young carers due to their care responsibilities. Including research taken from Growing Up in Australia: The Longitudinal Study of Australian Children (LSAC) which identified young carers in Year 9 performed lower in reading and numeracy skills.

One recommendation acknowledged the need for “further integration of care responsibilities and care relationships within the suite of tools used to identify ‘at risk’ young people for school programs designed for disengaged or vulnerable students”. It also noted requirement for a “means to address young carer specific needs in the provision of support and referral provided by these programs.”

When I consider career options and pathways, I acknowledge existing peer roles in the mental health system, and appreciate the importance of carer and consumer workers in health services. However, many of these are limited in hours, pay, authority and organisational status. Also, while some young (and adult) carers may be attracted to working in a caring field – it is important to open up a full range of options so they do not feel caring is all they can or should do.

I was drawn to study (my vocation) [redacted] due to my childhood circumstances and subsequent struggles creating a desire for social justice. Namely I chose this vocational pathway so I could access a means to end violence, poverty, reduce the impacts of mental illness and make the world a safer place for women, children and lgbtq communities. When I (commenced work in the human services fields) [redacted], it broadened my awareness of people different to me who are also disadvantaged in other ways. This expanded my learning of how I could contribute to change and feel more empowered. It provided an avenue to expand recognition and use of my skills beyond those I had gained for survival.

While I believe peer roles are a welcome development, it is my view that support for lived experience should not be limited only to sector entry level peer roles, but extend to supporting people of lived experience to access higher education, professional development and increase their earning capacity so as to provide social and economic equity in later life. The higher likelihood of carers experiencing dramatically reduced earning capacity over their lifetimes means accelerated support is needed to achieve this.

7. Is there anything else you would like to share with the Royal Commission?

While the consultations I attended were facilitated respectfully – I have been very disappointed at the haste of this process. The commission should reach out to people rather than expect all to ‘come to them’.

Translated materials have been insufficient and the interface with this commission inquiry is administrative and somewhat cold to the emotional preparation people require to make submissions. I have sought a number of private counselling sessions during the time I undertook this work. The financial cost to me has been significant, let alone for those who do not work either full or part time or who rely on support from workers employed in stretched mental health services.

Information from the Commission about ‘identity and disclosure’ as well as the use of information, how it is stored, for how long, where and by who has been ambiguous for those unfamiliar with Royal Commission processes. Given many people cite crime and sexual assault as a driver of poor mental health I think this is a neglectful oversight and no doubt resulted in many people not submitting.

Information from priority population groups (such as lgbtiq populations) I am sure are of interest to government, however in my opinion process thus far has been so rushed that even committed peak advocacy bodies and community groups, (let alone individuals) have struggled to keep up enough to collate and convey key issues from people who are already distressed.

For priority populations such as lgbtiq communities as raised in my submission, the overlay of grief and trauma discussing experiences of both the drivers and experience of poor mental health means this process severely risks triggering a decline back into ill health for many. Phone numbers of mainstream counselling lines are simply not enough, and information lines to leave messages for call back seem impersonal and

again demonstrate a lack of genuine understanding around the type of support people may need.	
Privacy acknowledgement	I understand that the Royal Commission works with the assistance of its advisers and service providers. I agree that personal information about me and provided by me will be handled as described on the Privacy Page. [redacted] [redacted]