05/07/2019

Royal Commission into Victoria's Mental Health System
Formal Submission

Introduction

My name is [redacted] I'm a [redacted]year-old female. I have just moved to a Youth Residential Rehabilitation Unit in [redacted] I lived in Fawkner for 20 years in my immediate family's home with my father, mother and twin sister. I've developed complex and severe psychiatric disorders and symptoms as a direct result of childhood emotional and sexual abuse committed by a family friend and public MHS trauma. I've also been diagnosed with ASD Level 1. If I had of received early psychiatric and trauma interventions in my childhood, I wouldn't be as disabled as I am now. I am unable to engage in education or study.

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Abbreviation Index

ASD - Autism Spectrum Disorder
BPD - Borderline Personality Disorder
CAMHS - Child and Adolescent Mental Health Service
CASA - Centre Against Sexual Assault
CLO - Consumer Liaison Officer
CM - Case Manager
CSA - Childhood Sexual Abuse
CYMHS - Child and Youth Mental Health Service
DDCS - Deputy Director of Clinical Services
ED - Emergency Department
EMH - Emergency Mental Health
ETP - Enhanced Treatment Plan
FOI - Freedom Of Information
GP - General Practitioner
IP - Inpatient
IWAMHS - Inner West Area Mental Health Service
LGA - Local Government Area
MDD - Major Depressive Disorder

MHA - Mental Health Act
MH - Mental Health
MHCSS - Mental Health Community Support Services
MHS - Mental Health Service
NGT - Nasogastric Tube
[redacted]
NUM - Nurse Unit Manger
OT - Occupational Therapy
PDD - Persistent Depressive Disorder
PICU - Paediatric Intensive Care Unit
PSO - Protective Services Officer
PTSD - Posttraumatic Stress Disorder
[redacted]
RCVMHS - Royal Commission Into Victoria's Mental Health System
[redacted]
RWH - Royal Women's Hospital
SOCIT - Sexual Offences and Child Abuse Investigation Team
YRR - Youth Residential Rehabilitation

Services

Paediatrician and School Counsellors

When I was 9 years old with a referral from our family GP my mother took me to a paediatrician because I was repeatedly threatening suicide and I was increasingly angry. The paediatrician thought that my behaviour was within the normal limits despite my mother's concern and instinct that something was wrong. The paediatrician asked me condescendingly "you don't really want to kill yourself, do you? Look at how upset your mum is". This question made me feel guilty for wanting to die. The paediatrician should have taken my situation seriously and referred me to CAMHS given the risk to myself and my anger. The paediatrician should have performed a comprehensive risk assessment. I saw the paediatrician two or three times. I was referred to the school counsellor for anger management. I was being sexually abused by a family friend. I don't expect the paediatrician to have known about the CSA, but she should have referred me to CAMHS due to my increased anger and suicidality. It was not within a school counsellors' scope of practise to treat a suicidal child. Something that should be explored is why my tests were within normal limits despite CSA. Medical complaints that began at the same time that the psychiatric and behavioural symptoms began weren't explored. During the childhood trauma I suffered persistent and unexplained headaches and abdominal pain.

Emergency Services

Ambulance Victoria

I've been transported in an emergency ambulance to both RCH and RMH EDs multiple times for psychiatric assessment and treatment because I was at serious imminent risk to myself or for medical assessment and treatment because I ingested an intentional medication overdose. Ambulance paramedics have always treated me with dignity and respect. Ambulance paramedics should receive training in all psychiatric disorders and crises. Ambulance paramedics don't seem to be educated on psychiatric disorders that aren't treated primarily by medications. Ambulance paramedics are surprised when I tell them that I'm not on any regular psychiatric medication, often they'll question whether I'm non-compliant with prescribed psychiatric medication.

Victoria Police

Childhood Sexual Abuse
I disclosed CSA to my mother at 11 years old. My mother took me to Fawkner Police Station to make a statement. I was treated with dignity and respect by the police officers and SOCIT. Although the experience was extremely distressing due to the nature of the crime the experience was positive. SOCIT didn't refer me to RCH CASA. SOCIT should have referred me to RCH CASA immediately.

Psychiatric Crisis
I've had contact with police officers and PSOs in psychiatric crisis. Police officer's and PSO's always treat me with dignity and respect. Police officers and PSOs only seem to be aware of bipolar, depression and psychosis/schizophrenia. Police officers and PSOs should receive training in all psychiatric disorders and crises. Once in crisis I met a police officer that was educated on dissociation. Although I was in crisis the experience was positive. The police officer was able to perform a detailed assessment. Because the police officer was educated, I felt comfortable knowing that he knew about dissociation. When I've been in the presence of police officers and PSOs in

crisis, I've been able to hear distressing statements over their radios (psych emergencies, sexual assaults). If the distressing statements over their radios could be reduced this may reduce any further distress. PSOs and police officers never tell me that I've been apprehended under a Section 351. Patients should be told that they've been apprehended a Section 351 because this would provide the patient with clear communication. In clearly communication with a patient this gains their trust.

General Practitioners

At the age of 11 my mother spoke our family GP about my self-cutting. The GP wasn't concerned and told my mother that, "it's something the kids are doing these days". This is the same family GP that my mother received a referral from regarding my suicidality and anger at the age of 9. The GP should have referred me to CAMHS, especially since my mother had expressed concern on two different occasions. All self-harm should be taken seriously and referred to MHS regardless of the physical severity.

As a teenager I self-presented to a GP after self-cutting because the cuts needed more than a simple dressing although they weren't life threatening. The GP looked at the wound briefly and told me "you need to attend an ED to speak to someone as to why I would do this to yourself". The GP didn't dress the wound at all. I walked out of the clinic despite being referred to ED for a psychiatric assessment. I then attended another GP within hours, this GP performed a brief psychiatric assessment and dressed the wound appropriately. I should have had my wound dressed appropriately at the first GP. I shouldn't have been referred to ED for self-harming without suicidal intent. All GP's should be trained in performing brief psychiatric assessments. If GP's are concerned for a patient immediate risk, they should call an emergency ambulance.

For issues relating to GPs dealing with Eating Disorders refer to "Eating Disorders"

Kids Helpline

I understand that KHL isn't a government service although the public MHS could learn a lot from KHL. I've had contact with KHL since I was a child although the majority of contact, I've had with KHL has been since 2018 when I was discharged from NWMH Youth MHS. KHL communicate extremely well with me, unlike public MHS. When my regular KHL Counsellor isn't available my Crisis Management Plan is always followed by the interim Counsellor. My Counsellor and I have worked collaboratively on my Crisis Management Plan which is a document that contains all the important information relevant to my case. Unlike the public MHS whose Crisis Plan contains a lot of irrelevant information. KHL Counsellors always have access to my Crisis Management Plan promptly. KHL's approach is to listen and allow me to ventilate, instead of telling me to do something externally (eg: take a shower, eat a meal, go for a walk, attend ED, call emergency services). KHL are very good at practicing a harm minimisation approach with me. We discuss realistic ways in which I can minimise the harm that I may cause to myself through self-destructive behaviours. This approach gains trust in the therapeutic relationship. This helps me retain some control of the situation. without the situation being taken out of my control. One evening I was talking to an interim Counsellor, who due to my risk decided to contact [redacted] Psychiatric Triage [redacted] Psychiatric Triage contacted emergency services without notifying me. Over the next 24 hours my psychiatric state worsened. The following evening, I spent over an hour on the phone to a KHL Counsellor, KHL had no other option but to call [redacted] Psychiatric Triage again. The Counsellor decided to contact me directly to inform me that emergency services had been contacted. They were attempting to prevent the previous night's lack of communication. For full details refer [redacted] Psychiatric Triage". My KHL Counsellor immediately removed [redacted] Psychiatric Triage as a contact on my Crisis Management Plan. From speaking to other patients KHL only contact emergency services in the most life threating situations unlike [redacted] Psychiatric Triage who contact emergency services, because they don't have the time to do a psychiatrically assess a patient.

[redacted]

[redacted] Adolescent Gynaecology

I understand that [redacted] Adolescent Gynaecology isn't an MHS. At 13 years old I attended my first gynaecology appointment with my mother. The gynaecologist needed to perform an invasive examination. I gave informed consent to the examination. I felt that I could withdrawal consent at any time. My mother was in the consulting room with me for the entire appointment. The way that RCH Adolescent Gynaecology examinations are performed

[redacted] Adolescent Medical Ward

I understand that the RCH Adolescent Medical Ward isn't an MHS although the Ward treats medically unstable eating disorder and psychiatric patients. I was admitted to the [redacted] Adolescent Medical Ward multiple times for medical treatment after taking intentional medication overdoses. Health practitioners always treated me with dignity and respect. Visiting hours are flexible and my mother was given the option of staying overnight by my bedside. I had unrestricted access to my electronic communication devises. Heath practitioners didn't object to me taking

photography of myself and medical equipment. Having access to my electronic communication devices helped my record admission and contact my family.

[redacted] Adolescent Psychiatric Ward

I was admitted to the [redacted] Adolescent Psychiatric Ward three times between October 2013 and February 2014. The admissions were so traumatic that I've developed PTSD symptoms including an intense fear that I'll be subject to restraint in hospital. I was 14 years old when the following events took place.

Autism Spectrum Disorder

Adolescent Psychiatric Ward health practitioners weren't trained in treating patients with ASD. Adolescent Psychiatric Ward health practitioners failed to make a referral to a [redacted] health practitioner that specialise in ASD. (eg OT, Developmental Medicine). The [redacted] Clinical Practise Guidelines: Autism and developmental disability: Management of distress/agitation" is an excellent and practical guideline that Adolescent IPU health practitioners failed to follow. The Adolescent Psychiatric Ward should consider following these guidelines when treating a patient with ASD. Adolescent Psychiatric Ward health practitioners should be trained in treating patients with ASD. When I refused to go to bed at the Ward's designated bedtime a nurse said to me "people like you (people with ASD) like routine, go to bed". I was forced to follow the Ward's inflexible routine; Adolescent Psychiatric Ward health practitioners made no attempt to incorporate my routine in the community, into my IP routine. Adolescent Psychiatric Ward health practitioners should have attempted to incorporate my routine in the community into my IP routine. They completely disregarded my routine and my need to have adequate time to process change when plans were changed. A health practitioner transferred my bedroom without my consent. I went on leave and when I returned to the Ward, I was notified of the bedroom transfer. The unexpected bedroom transfer was distressing. My mind was already unstable, and Adolescent Psychiatric Ward health practitioners were making my environment unstable, which caused further distress. I was granted overnight leave. The leave of absence was revoked merely because according to health practitioners, it was too late in the evening for my mother to pick me up. I became extremely distressed due to the sudden change of plan. I called my mother in a very distressed state. Whilst on the phone to my mother I was told off by Adolescent IPU health practitioners for being distressed. My mother was willing to come to the IPU to pick me up. My mother then spoke to the adolescent IPU health practitioners, they said that I was okay and not to come and pick me up that late at night. My mother and I should have received clear communication between the Adolescent Psychiatric Ward health practitioners to minimise miscommunication. A patient should not have their leave revoked merely because according to Adolescent Psychiatric Ward health practitioners it's the wrong time. A patient with ASD should have their individual needs considered. Parents should not be told that their child isn't distressed when their child is distressed. Health practitioners should value a parent's insight into their child's behaviour. Health practitioners complained if patients asked for more blankets. I now know that I'm hyporeactive to touch and that using multiple blankets grounds me.

Code Greys and Security Officers

On several occasions I witnessed Code Greys including patients being physically restrained by security officers. I witnessed a patient being dragged Code Greys are distressing for all patients. Adolescent Psychiatric Ward health practitioners didn't offer me and/or other patients individual and/or group debriefing after each Code Grey. Patients should be offered individual and group debriefing by health practitioners after witnessing a Code Grey. Health practitioners could have prevented every Code Grey that I witnessed. I would see that the patient was becoming increasingly distressed and Adolescent Psychiatric Ward health practitioners ignored the patient. Adolescent Psychiatric Ward health practitioners threatened to call a Code Grey on patients if they didn't do as they were asked (eg: go to their bedroom, or to stop arguing with an Adolescent Psychiatric Ward health practitioner). Code Greys should not be used to coerce or threaten patients. Code Greys are a medical response to clinical aggression not a punishment for patients who aren't doing as they're asked. Today I am paranoid of being restrained in hospital due to witnessing children being subject to restraint. Security officers escorted me from [redacted] ED to the Adolescent Psychiatric Ward on each admission. Security officers never introduced themselves (eg: name and role) and presented themselves in an intimidating manner (eg: lack of smile, and body language) I feared the [redacted] security officers and now I fear all hospital security officers. Security officers should introduce themselves to patients including their name and role in the patient's treatment, exactly like health practitioners introduce their name and role in the patient's treatment. Adolescent IPU patients told me that they were threaded with physical restraint if they attempted to absconded. A patient repeatedly attempted to abscond every time the main ward doors opened. Adolescent Psychiatric Ward health practitioners prevented the patient from absconding. The patient was repeatable told off for attempting to abscond. An aspect that needs to be explored is why patients would abscond instead of just merely focusing on preventing patients absconding.

Communication

I had no access to my electronic communication devices (eg: mobile phone). The Ward had one landline telephone that is located in the communal area for all 16 patients. Health practitioners ask you to limit your telephone calls to 15 minutes. Patients do not have access to the computers that are in the school room. Patients should have uncensored

and unrestricted access to their electronic communication devices. I know of several patients who smuggled their mobile phone into the Adolescent Psychiatric Ward. These patients used their mobile phones to take photographs of their bedroom (which is permitted in public health services) and to contact their family and friends. Health practitioners have excused the restrictive rules due to concerns that patients will photograph or video other patients. I have not known of a psychiatric patient that has taking photography or videography of another patient or a health practitioner. Visiting hours are limited to 2 hours each day. When I was admitted some days didn't have visiting hours at all. Visiting hours should be the same as [redacted] Wards (8am-8pm). Parents/carers are forbidden from staying overnight by their child's bedside. [redacted] were willing to change their rules and allow my mother to stay by my bedside overnight. Parents/carers should be permitted to stay overnight by their child's bedside in the Ward, because this would reduce patients distress and assist in their recovery. Visiting hours should be unlimited to parents/carers. I attempted to visit a friend after my discharge, who was in Ward. I was told ex patients are forbidden from visiting current patients. Ex patients should be able to visit current patients. The [redacted] has an excellent smartphone application called [redacted] it would be helpful if patients could actually access their mobile phone so they can access the application.

Complaints

When I was refused planned leave, I attempted to submit a complaint whilst I was admitted to the Adolescent Psychiatric Ward. I requested to talk to someone to complain about not being permitted planned leave, and the nurses gave me a hardcopy complaints form. I sat in the communal area completing the form when the NUM came and told me that submitting a complaint is very serious. Patients shouldn't be coerced or intimidated from submitting a complaint. In December 2017 I had a meeting with a CLO, two Adolescent Psychiatric Ward psychiatrists and the Adolescent Psychiatric Ward NUM. I discussed all of the issues that I've written about in this formal submission under [redacted] Adolescent Psychiatric Ward". The outcome of the meeting was for me to write a letter to one Adolescent Psychiatric Ward psychiatrist telling him what happened and what should have happened. I am a psychiatric patient that due to my symptoms is unable to write him the letter. My complaints weren't taken seriously as no immediate action was taken. The only changes that have been made to the Adolescent Psychiatric Ward is the visiting hours. The visiting hours used to be 2 hours, 3 days during weekdays. Visiting hours are now 2 hours, 5 days during weekdays. My complaint should have been taken seriously with my psychiatric symptoms considered.

Confidentiality

When I was discharged from the Adolescent Psychiatric Ward, I had forgotten my personal belongings, so I returned to the Adolescent Psychiatric Ward to collect them. A health practitioner brought out a plastic bag with my personal belongings in, when I arrived home, I discovered two sheets of paper in the plastic bag. The two sheets of paper were the Adolescent Psychiatric Ward handover including every patients name, age and confidential medical details. This breached up to 16 patients right to confidentiality. I thought that I disclosed the handover I would get into trouble, so I stored the handover in my bedroom then eventually I told my mother. I should not have been put in this situation. Being handed the document illegally has caused me immense distress. I have notified several Adolescent Psychiatric Ward health practitioners of the breach of privacy and confidentiality and all of them, have failed to take appropriate action. I have not been told what to do with the handover.

Eating Disorders

Health practitioners weren't trained in treating patients with eating disorders. On several occasions I purged by self-induced vomiting in my bathroom in the Adolescent Psychiatric Ward. The walls in the Adolescent Psychiatric Ward are incredibly thin so I don't doubt that they heard me vomiting. My purging should not have been ignored.

Education

Patients are forced to attend the school program from 9:30am - 3:30pm. Although it can benefit adolescence to stay engaged in their education, they shouldn't be forced to attend school in an acute episode of their psychiatric disorder. I was forced to attend the school program immediately after I was admitted. Health should come before education. Adolescent psychiatric patients should have an inpatient school program individually tailored to suit the patient.

Parents

My mother was never offered overnight accommodation on any of my three admissions to the Adolescent Psychiatric Ward where she was not permitted to stay overnight by my bedside whereas my mother was offered overnight accommodation immediately on my two-night admission to PICU where she was permitted to stay overnight by my bedside. Due to parents not being permitted to stay overnight by their child's bedside parents should be offered overnight accommodation. The NUM told me that regional patients are offered overnight beds. I know of a regional patient whose mother wasn't offered overnight accommodation during her entire five weeklong admission. My mother never witnessed health practitioners abusing patients.

Patient Bedrooms

Visitors aren't allowed in patient bedrooms. I was told by the NUM that visitors aren't allowed in patient bedrooms because a patient's bedroom is their own space, but health practitioners would come into my bedroom without my

consent. Visitors should be allowed in patient bedrooms with the patients consent. Visitors are permitted in patient bedrooms in other hospital Wards. Patient bedrooms are plain unlike other [redacted] Wards and areas of the hospital. The Adolescent Psychiatric Ward should look like the Adolescent Medical Ward with a green staff base, a yellow bedside table, a yellow couch, "earth" artwork and curtains. The lack of incorporating the artwork into the Adolescent Psychiatric Ward excludes psychiatric patients from the [redacted] Adolescent Psychiatric Ward bedrooms do not include a patient communication whiteboard. Patient bedrooms should include patient communication whiteboards to increase communication between families, patients and health practitioners. Adolescent Psychiatric Ward bedrooms do not include a lamp. Patient bedrooms should include a lamp. Adolescent Psychiatric Ward bedrooms do not include a clock. Patient bedrooms should include a clock especially since patients don't have their mobile phone to tell them time.

Searches

From 14 years old I was contact searched every time I presented to [redacted] ED without being admitted to a resuscitation bay. I was also searched every time I was admitted to the Adolescent Psychiatric Ward. I did not give informed consent to the contact searches. My mother did not give informed consent to the contact searches, my mother was never told about the contact searches by health practitioners. To prevent being contact searched when I presented to ED, I learnt that if I overdose on aspirin I would not be contact searched but instead be admitted to a resuscitation bay where I would have IV cannulas inserted immediately to administer IV fluid and medication infusions, ECG and vitals monitoring and a NGT inserted to administer activated charcoal. Aspirin overdoses risk renal failure. I was forced to choose between physical pain and discomfort or re-traumatisation of CSA through a contact search to seek psychiatric assessment. I chose physical pain and discomfort. A contact search meant that I was pressured to remove all my clothing quickly in front of one or two female nurses. I was not given the option of having my mother present. The explanation of the contact search was always very brief. My CSA history was not considered. A contact search is retraumatising to patients who have been sexually abused. The man who sexually abused me as a child forced me to remove my clothing and health practitioners forced me to remove my clothing. Patients should have a legal practitioner or advocate present for a contact search due to the invasiveness of a contact search. Patients should have the option of nominating a person to be present. Parents/carers of children should give informed consent and be present in the room with their child. An aspect that needs to be explored is why patients need to conceal dangerous items on their person.

Self-Harm and Suicide

On multiple occasions I attempted self-harm/suicide whilst on the Ward. Health practitioners did not respond appropriately. I would attempt self-harm/suicide to gain the attention that I needed by health practitioners and never received. When I attempted self-harm/suicide health practitioners would remove the dangerous item that I attempted self-harm/suicide with and then leave me by myself either in my bedroom or the health practitioners would lock my bedroom and I would sit in the communal area. When I attempted self-harm/suicide a health practitioner should have removed the dangerous item, performed a risk assessment and provided me with intensive crisis interventions. I would have received more intensive interventions from KHL than I did in an Acute Psychiatric Ward. When I was in the [redacted] Adolescent Psychiatric Ward a blood test was ordered, the health practitioner had difficulty accessing a vein due to self-harm scars on my forearm. The health practitioner said, "if you didn't do so much of this (self-cutting) it would be easier (to access a vein)". The comment made me feel guilty for self-harming. The health practitioner shouldn't have made a comment about my self-harm scarring. I don't have a problem with health practitioners asking about my self harm scars as part of a medical assessment but when you comment on my self-harm scars inappropriately. Health practitioners shouldn't comment on a patient's self-harm scars if it isn't part of a health assessment.

Trauma Informed Care

Health practitioners weren't educated on trauma informed care. Male health practitioners would walk into my bedroom to perform tasks (eg. wake ups). The sex offender walked into my bedroom and sexually abused me. The actions of the male health practitioners mimicked what the sex offender did. Health practitioners should have considered a female health practitioner to perform the task. A male health practitioner moved my personal belongings including my underwear from one bedroom to another bedroom when I was on leave. The male health practitioner touched my underwear. The male sex offender touched my underwear. I don't object to male health practitioners but in psychiatric crisis allowing a male health practitioner to perform tasks may be re-traumatising. A female health practitioner should have moved my personal belongings. Health practitioners never attempted to engage me in conversation about my CSA history despite my CSA being the reason I was admitted. Health practitioners should have attempted to engage me in conversation about my CSA history. Health practitioners weren't aware of the role of my [redacted] CASA art therapist. My [redacted] CASA art therapist visited me in the IPU multiple times. Health practitioners should have familiarised themselves with my community treatment team.

Treatment

I was pressured to sign documents on every admission about my treatment. I didn't understand what the documents were for and what I was consenting to. On my first admission my mother was not aware that I was forced to signed

documents. When on the second and third admissions I refused to sign the documents a health practitioner asked my mother to force me to sign the documents. I should have given informed consent about the documents. My mother shouldn't have been asked to force me to sign documents. It is unethical and immoral to ask a patient especially a child in psychiatric crisis to sign documents about their treatment. On my second or third admission I was forced to sign documents less than 48 hours after ingesting an overdose that effected my neuro-cognitive state. Patients should not be asked to sign documents when they are potentially neuro-cognitively affected. I was diagnosed with PDD on my first admission. I didn't receive any education about my PDD diagnosis. I should have received verbal and written education about my PDD diagnosis. The Adolescent Psychiatric Ward denies patients their health and human rights. There is no treatment for your psychiatric disorders. The health practitioners verbally abused me daily. If I failed to get out of bed health practitioners would verbally abuse me to get me out of bed. I was verbally abused for nearly dying from an overdose. I should not have been verbally abused for nearly dying from an overdose. Health practitioners complained if patients used blankets outside of the bedrooms. Patients should be able to use blankets outside of their bedrooms. Patients often don't have their parents/carers with them for ward rounds

[redacted] Adolescent Transition Service

I was not referred to the [redacted] Adolescent Transition Service on any three of my discharges from [redacted] I should have been referred to the [redacted] Adolescent Transition Service for each of the three discharges. The three discharges should have all happened when I was 18 as opposed to separately to minimise confusion and distress.

[redacted]e Autism Assessment Team

The [redacted] Autism Assessment Team performed several thorough assessments in late 2013. The [redacted] Autism Assessment Team always treated me with respect and dignity. My mother and I gave informed consent to the assessments. I was diagnosed with ASD Level 1 at 14 years old. Receiving a diagnosis of ASD Level 1 earlier would have been helpful.

[redacted]e Centre Against Sexual Assault

Intake

My treatment at CASA was the first therapy that I received for the CSA, three and a half years after I disclosed the CSA. I should have been referred to [redacted] CASA immediately after disclosing the CSA. People that disclose a sex crime should be referred to CASA immediately for assessment and treatment regardless of whether there are obvious or known psychological issues.

Treatment

I attended appointments at [redacted] CASA for two years. I was admitted to the [redacted] Adolescent Psychiatric Ward whilst attending appointments at [redacted] CASA. The Adolescent Psychiatric Ward trauma was ignored at CASA. My art therapist refused to recognise the trauma. My adolescent trauma should have been recognised and treated by CASA. My CASA art therapist followed the same risk management approach as [redacted] CAMHS by asking my parents to remove all the dangerous items from the household. [redacted] CASA didn't follow a harm minimisation approach. If I told my art therapist that I had a dangerous item at home, I was forced disclose the item without discussion. I felt unable to discuss my risk with my art therapist because my coping strategy would be taken away. The therapeutic relationship I had with my art therapist was helpful, I was able to process some of my childhood trauma.

Discharge

I was discharged against my will because according to [redacted] CASA I was too high risk to treat and I needed to see a psychiatrist. CASA and [redacted] Youth MHS refused to treat me together. If I were able to attend [redacted] CASA and [redacted] CAMHS until I was 18 years old my psychiatric disorders and symptoms would be treated comorbidly therefore increasing my quality of life. [redacted] CASA and [redacted] Youth MHS should work directly together.

[redacted] Child and Adolescent Mental Health Service Travancore

Intake

My first contact with CAMHS was when I was 12 years old when my mother referred our family. I had disclosed the CSA less than one year before our intake appointment. When we heard back from the intake practitioners, they said they were unable to help us. My family should have been accepted at CAMHS when I was 12 years old if not earlier. I wasn't accepted at CAMHS until I overdosed on paracetamol at 14 years old. I was accepted at CAMHS three years after I disclosed my CSA. Not accepting patients at CAMHS until they need medical treatment for their psychiatric disorders tells patients that they need to be medical unstable to receive psychiatric treatment. Now health services wonder why I've gotten addicted to overdosing.

Treatment

My psychiatrist expressed concern about giving me to much therapy despite being given no treatment for six years. I don't believe that my psychiatrist understood how unwell I was. He failed to diagnose and treat my BPD and PTSD. There was no therapy at CAMHS, just case management. Patients need more than case management. [redacted] CAMHS did not follow a harm minimisation approach with me. My treatment team told my parents to lock up all the dangerous items in the house. My treatment team should have put effort into learning about why I wanted to self-harm and/or suicide instead of just preventing it. My psychiatrist prescribed me risperidone at 14 years old, I suffered unpleasant side effects such as rapid weight gain and severe extrapyramidal reactions. A child should not be prescribed an antipsychotic as a first line treatment especially when they don't have a psychotic disorder or symptoms. I was prescribed fluoxetine in the [redacted] Adolescent Psychiatric Ward and the fluoxetine was continued at [redacted] CAMHS Travancore. The psychiatrist was not honest about how long the medication may take to take effect; I was on fluoxetine for 12 months. I shouldn't have been kept on fluoxetine for that length of time. I lost a lot of hope in psychiatric medications with the way I was prescribed fluoxetine. I would take the fluoxetine day after day, week after week, month after month expecting it to take effect. the psychiatrist should've been honest and told me that I could be on fluoxetine for up to 12 months. After fluoxetine, I was prescribed mirtazapine. The medication made me increasingly suicidal within less than one week. My repeated requests and pleas to be taken off mirtazapine were dismissed by the psychiatrist.

Discharge

I was 15 years old when I was discharged from [redacted] CAMHS. I wasn't aware tha[redacted] CAMHS discharges patients at 15 years old. At an appointment with the psychiatrist I was told that I was going to be discharged because I had turned 15 years old. Within two weeks I was discharged completely from [redacted] CAMHS. I went from thinking that I would be at CAMHS until I was 18 years old to discharge all within two weeks. Discharge should be planned. MHS until I was 18 years old to discharge within two weeks. [redacted] CAMHS should see patients up to 18 years old, if not 25. There was no formal handover between services. I was discharged on mirtazapine with increased suicidality. I was forced to wean myself off of mirtazapine without medical monitoring. I shouldn't have been forced to wean myself off of mirtazapine. The psychiatrist should have

[redacted] Emergency Department

I was always treated with respect and dignity by health practitioners in the ED. [redacted] ED health practitioners were educated on trauma informed care. [redacted] ED health practitioners were educated on ASD Level 1, health practitioners were aware of my hypersensitivity to noise.

[redacted] Medical Ward and Medical Short Stay Ward

On multiple occasions I was admitted to the Medical Ward or the Medical Short Stay Ward after intentionally ingesting a medication overdose because a bed wasn't available on the Adolescent Medical Ward. I was treated with respect and dignity by the health practitioners in these Wards.

[redacted] Paediatric Intensive Care Unit

I was admitted to PICU after intentionally ingesting a medication overdose. I was treated with respect and dignity by health practitioners in the PICU. While in a semi-conscious state I attempted to remove my NGT, my PICU nurse performed a least restrictive partial physical restraint in a calm and dignified manner by gently holding my hand away from my nose whilst explaining to me as to why the NGT needed to stay in place. The MHS could learn lot from the way patients are restrained in medical ICUs and medical wards. When I was medically stable PICU wanted to transfer me to the Adolescent Psychiatric Ward, my mother and I refused. Instead of forcing me into the Adolescent Psychiatric Ward like the psychiatric team the Head of PICU came and spoke to my mother and I about why we were refusing to be transferred and listened to our concerns. The PICU health practitioners were shocked

[redacted]

[redacted] Mental Health

[redacted] as a system is extremely difficult to understand. The health practitioners that work for [redacted] don't even understand the system. Each service withi[redacted] doesn't communicate with each other.

[redacted] Youth Mental Health Service

Intake

My first contact with [redacted] was when I was discharged from RCH CAMHS at 15 years old. I received a letter from the NWMH Youth MHS BPD Clinic/Program agreeing that they were not a suitable service as I was engaged with RCH CASA. NWMH Youth MHS must have known about my BPD at 15 years old because the BPD Clinic/Program sent me a letter[redacted] CASA and I should have been notified of the diagnosis. When I was 16-year-old [redacted] CASA decided that I was too difficult and high to treat, and I needed to see a psychiatrist. [redacted] CASA transferred me to[redacted] Youth MHS. The intake was extremely traumatic, I was not told that I was being assessed

for BPD. I accidently saw a piece of paper that the intake practitioner during the intake appointment that read "BPD II". I immediately lost trust in [redacted] Youth MHS. I notified the [redacted] Youth MHS health practitioners of my distrust in the service due to their lack of communication. I received no apology from my CM and my CM made no attempt to repair the damage that the service had caused. I was extremely distressed in each appointment. My CM told my mother not to continue attending appointment due to my distress. I self-discharged and a Transition/Discharge letter was sent home saying that I was diagnosed with ASD Level 1, MDD and Troublesome Personality Changes. I thought that I was diagnosed with ASD Level 1, PDD and PTSD. My psychiatric diagnoses should have been directly communicated and discussed with me. The intent of the assessment should have been directly communicated with me. [redacted] Youth MHS should have apologised immediately and attempted to repair the damage immediately. I reluctantly returned to [redacted] Youth MHS when I had no other option.

Treatment

After the traumatic intake I was extremely reluctant to engage with [redacted] Youth MHS and my CM. My CM put no effort into engaging me in the service or repairing the damage that they had caused from lack of communication. I received more communication from the research student psychologists than I did my CM. My CM didn't offer to meet me outside of the service (eg. my residential address). My CM should have attempted to engage me in the service by meeting me outside of the service. I wasn't encouraged to call [redacted] Youth MHS Psychiatric Triage Service. My first and second CMs performed CAT on me without my informed consent. I did not know that CAT was being performed on me. This further increased my lack of trust in the service. Patients should give informed consent to their treatment and offered education about their treatment. Due to the lack of trust with the first and second CMs and the traumatic [redacted] CASA discharge I became emotionally attached to my first psychiatrist. My experiences with psychiatrists up until I met my first psychiatrist were incredibly negative. My first psychiatrist was like a CM in that I developed a stronger therapeutic relationship with him than I did my first and second CMs. My first and second CMs shouldn't have been so neglectful to the point where my psychiatrist had to act as a CM. My first psychiatrist prescribed me quetiapine without my informed consent. I was reluctant to take quetiapine because of my previous extrapyramidal reaction to another antipsychotic. I should not have been prescribed quetiapine. My first psychiatrist prescribed me venlafaxine. I gave informed consent and I wasn't told off for abruptly stopping the medication whilst on a high dose. My first psychiatrist understood how traumatised I was, he used term like "complex PTSD". He read past my grossly inaccurate medical record. After my second CM completed performing CAT on me my first psychiatrist and second CM attempted to discharge me. When I received a third CM, I was extremely reluctant engage with her due to the negative experiences with the previous two CMs. Eventually I was able to trust my third CM who listened to my repeated requests to be formally diagnosed and she formally confirmed my diagnoses of ASD Level 1, MDD, BPD, PDD and PTSD after much distress and miscommunication between [redacted] and [redacted] Youth MHS. My third CM educated me on advance statements, three years after advance statement were introduced into the MHA. My first and second CMs should've educated me on advance statements. My third CM was excellent at practising a harm minimisation approach with me. Unlike previous health practitioners I was able to discuss the ways in which I could minimise the harm to myself through my self-destructive behaviours. My third CM didn't force me to give her the dangerous items I used to self-harm. My third CM taught me about dissociation and grounding, she invested the effort into teaching me grounding techniques that uses my senses. To this day I continue to use the techniques that she taught me. My first psychiatrist eventually gave up on me, he refused to see me for three months. The decision was not collaborative, and I didn't give informed consent to the decision. His decision left me feeling hopeless. On the first appointment I had with him after he refused to see me, he told me that he would be transferring clinics. The psychiatrist I was transferred to was the psychiatrist that was on the transition/discharge summary. I didn't trust the second psychiatrist at all due to her previous lack of communication. My third CM and second psychiatrist sat down with me and went through my medical record at my request. The gross inaccuracies on my medical record were appalling. My CSA was horrifically invalidated. My medical record stated that the context of the CSA was "touching over clothing at 8 years old" with no other details. The sex offender digitally penetrated me and emotionally abused and manipulated me for years. My third CM and second psychiatrist apologised for the miscommunication although the damage had already been done. This inaccuracy told me that the public MHS didn't believe that the sex offender digitally penetrated me and emotionally abuse me. My second psychiatrist asked me "what would you like me to write". The fucking inaccuracies were not investigated. The inaccuracies should have been investigated. [redacted] Youth MHS didn't know about my [redacted] gynaecology history. My gynaecology history is relevant to an MHS because the CSA included my reproductive system and I saw gynaecology for a reproductive deformity. My gynaecology condition effects my menstrual periods and sex life which are all related to my childhood trauma history. [redacted] Youth MHS should have directly asked me if there was any information in my history that I thought was important.

Discharge

The 2-year treatment limit is incredibly harmful and damaging. No other health service has such a strict time limit on their services. Paediatric, adolescent, youth, adult and aged health services have age limits, but they don't have a time limit. When you're discharged from a service purely due to lack of funding you are telling patients that funding is more important than their life and health. [redacted] Youth MHS discharged me due to lack of funding although due to the discharge I've had to access a Headspace GP

[redacted] Youth Psychiatric Ward

I refused to be admitted to the Youth Psychiatric Ward due to the [redacted] Adolescent Psychiatric Ward trauma. I was desperate and asked for an admission. My CM refused my request immediately, her excuse was that there were no beds. My desperation wasn't appreciated. I should have been placed on a waitlist.

[redacted] Youth Psychiatric Triage Service

My experience with [redacted] Youth Psychiatric Triage Service was extremely negative. I didn't have contact with [redacted] Youth MHS Psychiatric Triage Service until the last year that I was at [redacted] Youth MHS. Health practitioners hung up on me multiple times. Health practitioners shouldn't hang up on patients. I was told off for swearing even though I was swearing about my situation as opposed to swearing at the health practitioner although one health practitioner understood that I wasn't swearing at him. I would ring in crisis; the health practitioner would increase my distress then insist on ending the call because the call wasn't helpful because I was becoming increasingly distressed and without repairing the damage that they had caused. Often the wait times to speak to a health practitioner were hours. Health practitioners would tell me that they had spent too much time speaking to me and that they needed to speak to other young people that were actually in crisis, implying that I wasn't in crisis. Some health practitioners knew how manage my distress, understood my individual needs and validated my crisis.

[redacted] Community Team

Intake

I was referred to [redacted] [redacted]Community Team because [redacted] Youth MHS discharged me because of their 2-year treatment limit. My experience with [redacted] Community Team has been extremely negative.

Treatment

One thing that [redacted] did well was when I was struggling to engage with service my CM met me outside of the clinic. My main issue with [redacted] is lack of communication. On multiple occasions [redacted] have failed to communicate with me and other [redacted] health practitioners. [redacted] will refuse to admit their mistakes and improve their service. Health practitioners refuse to follow my ETP, [redacted] excuse their health practitioners because they're not my treatment team but the purpose of my ETP is to communicate relevant information about my case. My ETP took six months to complete and was submitted with grossly inaccurate information. It took several calls to the MHCC to be heard. When my CM was on leave, I attended an appointment with the Duty Worker, she contacted a Duty Consultant Psychiatrist to assess me. He threatened to admit me to the Adult Acute IPU and gave me no other option than being referred to CATT. My trauma history should've been considered. My Consultant Psychiatrist referred me to the DDCS for a second psychiatrist opinion because I'm too complex for to treat. [redacted] took three attempts to make an appointment with the DDCC because [redacted] health practitioners continued to forget to tell the DDCS that he had an appointment with me. I had an appointment with the DDCS. The DDCS validated my Adolescent Psychiatric Ward trauma and admitted that I've fallen through the cracks of the MHS, this. was incredibly validating. My mother and I were told we would receive a report. Now months after the DDCS appointment we are told we must go through FOI to receive a report. Ironically now [redacted] says that I'm too complex for the public MHS when just six years ago my CAMHS psychiatrist was concerned about giving me too much therapy. [redacted] admit that they aren't the right MHS for me, they treat adults primarily with psychiatric disorders primarily treated by medication not a young person with psychiatric disorders primarily treated by trauma therapy. [redacted] has caused me much distress and re-traumatisation through miscommunication. I have lost any hope I had left. [redacted] admit that they don't know what they've doing for me, they've given up on me. I've given up on me.

[redacted] Crisis Assessment and Treatment Team

CATT doesn't communicate, CATT doesn't contact me when my crisis plan states that communication is in my best interest. CATT have hung up on me multiple times. This tells me that my life is not

[redacted] Eating Disorder Coordinator

I was referred to the EDC when my CM became aware of my frequent binging and purging. I've always been treated with respect and dignity by the EDC.

[redacted] Adult Acute Inpatient Unit

I refuse to be admitted to an Adult Acute IPU because of my PTSD symptoms from [redacted] Adolescent Psychiatric Ward trauma. The [redacted] Adult Acute IPUs admits patients up to 65 years old. Admitting youth with patients up to 65 years old isn't therapeutic. They have a women's only area. Although from what I've heard directly from female patients' males come into the women's only area. This puts female patients' sexual safety at risk. This means that I do not have an alternative Acute Psychiatric Inpatient option that meets my needs. The public MHS should have an alternative available. No one appreciate how this impacts me.

[redacted] Prevention and Recovery Centres

There is no Youth PARC in the [redacted]. My only PARC option is a PARC where adults up to 65 years old can reside. I had a meeting with PARC, and I asked them if sex offenders may be residing at PARC, they said that if a sex offender was residing at PARC they would be assessed as low risk. As a victim of CSA residing with sex offenders would put my sexual safety at risk. Victims of crimes should not be admitted to a PARC where a convicted sex offender is residing. This puts the victim's safety at risk and isn't therapeutic for the victim. A Women's PARC or a Youth PARC would be therapeutic in my situation (a young woman who was sexually abused by an adult male). Because I haven't been able to access a therapeutic sub-acute service like PARC my psychological state has declined. I now need a long-term residential service Youth Residential Rehabilitation.

[redacted] Psychiatric Triage Service

I've had very limited contact with [redacted] Psychiatric Triage Service. The contact that I've had with [redacted] Psychiatric Triage Service has been extremely negative. I contacted KHL in psychiatric crisis. KHL decided to contact [redacted] Psychiatric Triage due to my risk. I consented to the contact as I understand duty of care laws and I wanted to avoid the emergency department and services. [redacted] Psychiatric Triage decided to contact emergency services without notifying me. [redacted] Psychiatric Triage Service sent the police to my residential address. My father was at my residential address. I received no services that night, The My psychiatric state worsened over the next 24 hours. I became extremely paranoid that if my ETP wasn't going to be followed I was going to be restrained. I contacted KHL again the next day. KHL decided to contact

The health practitioner that failed to notify me twice of the emergency services excuse was that she didn't know why she didn't notify me of emergency services being contacted. I was told that it is protocol to notify a patient if emergency services are contacted. The health practitioner broke protocol.

[redacted] Psychiatric Triage Service is meant to be a psychiatric triage service although due to such limited resources [redacted] Psychiatric Triage Service is a referral service [redacted] Psychiatric Triage Service use emergency services as a psychiatric assessment service as they don't have the time and resources to assess patients. I was told that often there is only one or two health practitioners on a shift. Patients often wait hours to get into contact with a health practitioner.

The Royal Melbourne Hospital Emergency Department

I've always been treated with respect and dignity by medical practitioners in ED. The first time I attended RMH ED a medical practitioner offered to dress my superficial self-inflicted cuts. The medical practitioner didn't have to offer to dress my superficial self-inflicted cuts, but he did. The medical practitioner spoke to me in a calm tone of voice and listened to me. I attended RMH ED, the health practitioner acknowledged how difficult it was for me to attend ED. The health practitioner was apologetic that she couldn't offer me much. She offered me temazepam and I was discharged.

Private Psychologist

Because the male that emotionally and sexually abused me as a child was convicted, I am able to receive weekly VOCAT funded psychology sessions. More often than not the sex offender isn't convicted therefore the victim is unable to access VOCAT funded psychology sessions. Victims of crimes should have access to trauma therapy even if the alleged perpetrator isn't charged. I'm extremely fortunate to have access to funding from VOCAT. My private psychologist has assessed my adolescent trauma with PTSD screenings and testing, this in itself is extremely validating.

The Royal Women's Hospital of Melbourne

I understand that the RWH isn't an MHS although the RWH treats many women with CSA histories. I've attended the RWH Young Women's Gynaecology Clinic since 2018. I'm always treated with dignity and respect by health practitioners. My gynaecologist considers my trauma history. My gynaecologist ordered an external abdominal ultrasound instead of an internal ultrasound. Psychiatric Wards could learn a lot with how the RWH treats women with a history of CSA.

Youth Residential Rehabilitation

I have had contact with YRR Essendon since 2019. My experience has been extremely positive. The youth workers have always treated me with dignity and respect. I would not have had to access YRR if I had of received early interventions and adequate MHS. If I had access to a therapeutic sub-acute service, I wouldn't have become so disabled and need a long-term residential service. The YRR youth workers are trained in trauma informed care. When the male youth worker performs a welfare check he doesn't come into my bedroom unless it is absolutely necessarily. The YRR youth workers consider my ASD Level 1, my psychiatric disorders and my trauma history,

Psychiatric Inpatient Ward Trauma

The [redacted] Adolescent Psychiatric Ward trauma is not recognised by public health services as a traumatic event. I have fought with [redacted] Youth MHS and [redacted] to get the trauma recognised. The PTSD symptoms that I've developed as a direct result from the trauma is not recognised by public health services. Six years later I still experience nightmares of the traumatic events I experienced. I still experience flash backs of the traumatic events. I still experience intrusive memories of the traumatic events. I still avoid things that remind me of the traumatic event. Immediately after the admissions I became attached to my teddy bear Wally, I had not previously been attached to him. After the admissions I began having difficulty falling asleep, my only other sleeping difficulties were when I was being sexually abused. Health practitioners minimise the trauma by saying that "the Adolescent Psychiatric Ward wasn't a helpful place", Health practitioners don't understand how the traumatic [redacted] Adolescent Psychiatric Ward was. The [redacted] Adolescent Psychiatric Ward admissions were a traumatic event. The [redacted] Adolescent Psychiatric Ward was just as traumatic as the CSA. When I refuse to be admitted to a Psychiatric IPU the health practitioner doesn't try to understand why I don't want to be admitted. Instead the health practitioner threatens a psychiatric admission even when I tell them that my mother won't allow it. When a patient refuses a psychiatric admission health practitioner should attempt to understand why the patient is refusing an admission as a Psychiatric IP trauma history may be possible. Patients that have been subject to Psychiatric IPU trauma should be provided with an alternative option that is more intensive than what AMHS CATTs can provide. The government needs to come up with another option, it is not good enough that I'm told that I have no crisis option other than Psychiatric Triage and CATT. I didn't take Psychiatric IP away as an option. I refuse to be admitted to a Psychiatric IPU no matter how high risk I become or how life threating my symptoms become. I would rather die than admitted to a Psychiatric IPU again. I would rather have a male perform an internal ultrasound. No words will justify how traumatic the [redacted] Adolescent Psychiatric Ward was.

Fear of Restraint

Due to witnessing physical restraint I have developed an intense fear of being restrained in hospital. The fear of restraint is so severe that I haven't overdosed in over 2 years despite the persistent intense urge to overdose. The urge doesn't fluctuate in intensity. The pressure to overdose is just as strong of the fear of being restrained. When I overdose, I will delay attending ED because I'm petrified that I'll be restrained in hospital. I may suffer renal failure due to my fear. No words will justify how traumatised I am. If I didn't witness physical restraint, I wouldn't have developed this fear.

Psychiatric Disorders

Autism Spectrum Disorder Level 1

I was diagnosed with ASD Level 1 when I was 14 years old. The only health service I've received for my ASD Level 1 was an appointment with an ASD Coordinator at [redacted] Youth MHS. I asked for another appointment, but my request was refused. I asked for the results of the appointment but they I was never discussed with me. MHS have never treated my ASD adequately. Patients with ASD.and co-morbid psychiatric disorders need to have their disorders treated together. Health services also need to identify ASD Level 1 sooner to enable patients to receive treatment during childhood therefore increasing their quality of life. A health practitioner in [redacted] ED performing a psychiatric assessment said to me "you don't look autistic". All health practitioners should be educated and trained in ASD including female ASD Level 1.

Borderline Personality Disorder

The stigma surrounding BPD is incredibly harmful and potentially lethal. In psychiatric crisis I was transported to [redacted] ED in an emergency ambulance by ambulance paramedics and police officers apprehended under a Section 351 because I was an immediate serious risk to myself. I was assessed by an [redacted] EMH nurse. She told me that if I was going to kill myself, I would have done it by now and that people like me (BPD patients) don't kill themselves and that people who kill themselves don't present to the ED. She told my 1:1 nurse to leave me to cry. She collected all of my belongings making it clear that I wasn't welcome. She verbally told me that I could stay and offered me a taxi voucher although her actions told me otherwise. I felt that my life was worthless. I had never been in a taxi alone before. I had never been in an adult ED alone before. I walked out of ED crying and dissociating in the dark. I called a relative who picked me up. It is not acceptable for a health practitioner to treat a patient like this. The EMH nurse also attempted to contact my father without my consent even though I had given another [redacted] ED nurse an adult friends name and mobile phone number. The EMH nurse should have attempted to contact my adult friend with my consent. Contacting my father is a breach of my privacy and confidentiality. The EMH nurse invalidated my psychiatric ward abuse. She questioned whether that contact searches were contact searches. The statements she made are factually incorrect. BPD patients do die by suicide. Many people who die by suicide have made previous suicide attempts and/or attended ED. Health practitioners should be educated about severity and risks of BPD. Health practitioners need to be aware of a young person's circumstances [redacted] Youth MHS did not assist or encourage me to file a formal complaint. I needed to be told that I was treated incorrectly but I was told that it was ok through their actions.

Complex Patients

Autism Spectrum Disorder and Borderline Personality Disorder

There are no public health services equipped to assess and treat the complexities of my cooccurring ASD Level 1 and BPD. I often don't understand tone of voice and facial expression and this symptom combined with fear of abandonment is extremely distressing and confusing because often I will misinterpret tone of voice or facial expression as abandonment. The risk to myself is complicated due to my rigid thinking. Health practitioners don't know how to manage my persistent overdose urges that won't decrease due to my rigid thinking. Other patients at risk to themselves will often have episodic urges that fluctuate in intensity. Despite not giving in to the overdose urges for over two years due to fear of restraint my overdose urges continue to increase. In 2019 NWAMHS contacted the [redacted] The [redacted] indirectly assessed me using my inaccurate medical record. The [redacted] refused to assess me in person. They said that my BPD needs to be treated first. My BPD and psychiatric disorders have been treated separately at different times for years.

Psychiatric Disorders and Trauma History

When victims of trauma develop severe psychiatric disorders and/or symptoms each health service manages a different aspect of their trauma. [redacted] reated my BPD, [redacted] CAMHS treated my depression, self-harm and suicidality, [redacted] CASA treated my CSA and PTSD. Patients should be able to access multiple specialist services at the same time. Services should work together collaboratively to treat each aspect of the patient's trauma. If trauma patients were able to access both CASA and MHS at the same time this would increase a patient's quality of life because all aspects of their trauma would be treated.

Eating Disorders

I've engaged in eating disorder behaviours since the CSA began. I was diagnosed with EDNOS/OSFED by [redacted]H, but I wasn't told about the diagnosis or offered any treatment. I should've been told about my EDNOS/OSFES diagnosis and I should've been offered treatment. All patients should be assessed and treated immediately after eating disorder symptoms develop. I was then undiagnosed with EDNOS/OSFED by [redacted] Youth MHS and wasn't told that I was undiagnosed. I [redacted] Youth MHS should've reassessed and treated me for my eating disorder symptoms. My [redacted] Youth MHS transition/discharge summary revealed my EDNOS/OSFED diagnosis history. I was diagnosed with BN at 19 years old by the [redacted] EDC, over 10 years after I first developed eating disordered symptoms. I now binge and purge daily. If I had of received early intervention including adequate assessment and treatment my symptoms may not have become so severe.

Headspace Glenroy

My [redacted] CM referred me to Headspace Glenroy's Youth Heath Clinic when I notified her of hematemesis during episodes of self-induced vomiting. I attended multiple GP appointments at Headspace for medical assessment and monitoring. The Headspace GPs always treated me with dignity and respect. On my first the Headspace GPs Unfortunately, I was transferred to a regular GP because Headspace Glenroy has such limited GP appointments available to patients and due to the frequency of my self-induced vomiting, I need to be monitored by a GP weekly. Regular GPs aren't educated on the risks of eating disorders. I've seen regular GPs before and after I attended Headspace Glenroy and all of them have been very dismissive and ignorant to the potential risks of restricting and purging. Regular GPs aren't concerned because I'm not underweight, they don't understand that my electrolytes need to be monitored frequently. I had a detailed referral from Headspace GP and Eating Disorder Guidelines. If I was able to see a Headspace Glenroy GP weekly, I would be medically monitored by a GP that understands the risks of eating disorders. If GPs were educated into the risks of eating disorders I could be medically monitored. Currently I'm not being monitored medically.

Purging Methods

In 2018 after discharge from [redacted] Youth MHS my eating disorder behaviours increased. I bought NGTs online to use to purge. I binge on high calorie liquids and then I insert the NGT just like a health practitioner does in hospital and I drain the contents of my stomach out with a syringe. The only health practitioner I've told was a Headspace Glenroy GP. Eating disorder behaviours such as this one need to be considered and explored by health practitioners. Restricting patient's access to buying NGTs isn't the answer. Access to NGTs isn't the issue, it's that my eating disorder behaviours have become so severe that I need to engage in these behaviours. Early intervention is the answer, if I have of received early interventions, I wouldn't have engaged in such disordered behaviours.

Other

Adult Mental Health Services

Adults over 25 need more Adult AMHS, Adult CASAs, Adult MHCSS and Adult PARCs. These adults have been neglected throughout their childhood, adolescence and youth by MHS. These people are now severely unwell adults that desperately need the treatment that they've been denied for years and in many cases decades.

Early Intervention

All people should be referred to their Area MHS immediately after the patient, family, friend, emergency services or health practitioner requests a referral. Referrals should be accepted. People should receive a comprehensive assessment within months of a referral. Currently patients wait years and in many cases decades to be referred to an AMHS. Currently when patients are accepted to an AMHS they often are never provided with intensive psychotherapy. Patients often see a psychist for medications a CM for case management.

Medicare Better Access Mental Health Plans

Medicare Better Access Mental Health Plans which provides patients with 10 psychology sessions per calendar year is nowhere near enough to provide patients with intensive psychotherapy. Psychology is so much more complex than medicine. There should not be a limit on the number of psychology sessions a patient can receive per year. Other health services don't have such limits. Yes, most patients see their specialist quarterly but there isn't a limit, if the specialist decides that they need to see their patient monthly they do.

Medications

Psychiatrists should avoid prescribing children, adolescence and youth any psychiatric medications. At 18 years old I'd been prescribed with two different antipsychotics despite not having a psychotic disorder. Psychiatrists should avoid practising polypharmacy. Patients are often prescribed multiple harmful medications with severe side effects.

Mental Health Act

The MHA is too interchangeable, using words like "reasonable" leaves too much grey area left to individual interpretation.

Advance Statements

Advance statements should come into effect for voluntary patients. Currently patients must be subject to an Order under the MHA 2014 for their advance statement to come into effect. There is no reason as to why advance statements don't come into effect for voluntary patients. Health practitioners and patients need more education on advance statement. Having one A3 poster in a MHS waiting room isn't enough education.

Bodily Restraint

The use of bodily restraint should generate an incident report immediately into the reason for the bodily restraint. The patient should be debriefed immediately after the bodily restraint. Health practitioners and security offices should be subject to bodily restraint in their training. The bodily restraint should be performed in the context in which patients are subject to. A medico legal lawyer should be contacted to assess the patient's health and human rights.

Communication

When restricting a patient communication, a medico legal lawyer should be contacted immediately to review the decision and ensure that the decision is least restrictive. This will prevent health practitioners from restricting a patient's communication unnecessarily.

Contact Search

Patients should have a medico legal lawyer appointed/present to them if a health practitioner orders a contact search. Patients should be debriefed immediately after a contact search. This will ensure that contact searches are least invasive.

Orders

Patients subject to an Order under the MHA should be appointed a medico legal lawyer immediately after the Order is made. Currently acutely unwell psychiatric patients have to advocate for themselves in that they have to contact advocacy services themselves. Most patients don't have an Advance Statement or a Nominated Person.

Mental Health Service Catchments

MHS catchment shouldn't be as strict as they are. I lived in Moreland City Council and moved to Moonee Valley City for Youth Residential Rehabilitation. I've had to transition from [redacted] to [redacted]S. Both LGAs are under [redacted]

and [redacted] I shouldn't have to transfer. During transfer whilst I'm still attending appointments at [redacted] and living at YRR in [redacted] if I'm referred to CATT, I must be referred to [redacted] CATT even though my Community Team

Psychiatric Inpatient Units

Psychiatric IPUs don't offer patients individual nonpharmacological treatment. There is no therapy. I receive more intensive interventions form KHL than I would in an Acute Psychiatric IPU.

RCH CYMHS

Currently RCH CAMHS is a 0-15 service and [redacted] Youth MHS is a 15-25 service with a strict two-year treatment limit. 17-year old's are discharged to Adult AMHS whilst still attending [redacted] Adolescent Medicine and [redacted] ED. [redacted] CAMHS and [redacted] should be combine their services making RCH CYMHS a 0-25 MHS without a treatment time limit. This will allow children, adolescence and youth in north western and western metropolitan Melbourne to receive assessment and treatment without transition/discharges and time limits.

Suicide and the Media

When someone dies from suicide by train the media refuses to use the word suicide. The media will tell affected public transport customers that there has been a "police incident". The term "police incident" is also used for suspected terrorism. This is extremely stigmatizing and implies that suicide is a crime. The media constantly talks about the road toll, yet we don't talk about the suicide toll nearly as frequently and bluntly. I agree with the "#chatsafe" Guidelines including not referring to the method that a person who has died by suicide used as this may lead to a suicide contagion.

Terminology

MHS refers to people who access MHS as "clients" or "consumers". I prefer to be referred to as a "patient" because people who access other health services are referred to as patients. I don't like the terms "mental health" or "mental illness", I prefer the terms "emotional disorder", "emotional health", "emotional illness", "psychiatric illness", "psychiatric disorder", "psychiatry" and "psychology". Each MHS has different terminology

Youth Psychiatric Inpatient Units

Admitting young adults to Psychiatric Wards with patients up to 65 years old isn't therapeutic. Young adults have individual needs that are specific to their age group.

Victims of Crimes

Victims of crimes should not be treated with serious offenders in both community and inpatient settings because this puts victim's safety at increased risk.

I started writing this formal submission over six months ago. Writing this formal submission has been extremely distressing and re-traumatising. Unfortunately, the RCVMHS is too late for me and so many others. I will die prematurely from self-harm, suicide, my eating disorder or my self-destruction. I can't stress the trauma I suffered in [redacted] Adolescent Psychiatric Ward, the posttraumatic stress symptoms that I've suffered as a direct result and the MHS refusal to assess and treat the trauma.

[redacted]

[redacted]

Thank you for taking the time to read my formal submission, please don't hesitate to contact me.

Address: [redacted]
Email: [redacted]
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