Royal Commission into Victoria's Mental Health System

I wish to make a submission to the Royal Commission into the Victorian Mental Health System.

I want to bring to your attention some major concerns we have had with our daughters mental health treatment.

Our daughter, "X" commenced treatment with the [redacted] CYMHS when she was 13 years old for Borderline Personality Disorder (BPD), depression, anxiety, self harming and anorexia – binge/purge subtype . During this time she developed a strong therapeutic relationship with her therapist & treatment ranged from mostly fortnightly to sometimes twice weekly appointments when she was suicidal. Once "X" turned 18 she no longer fell into the Alfred CYMHS catchment area despite the Alfred CHYMS service being walking distance from our home & treating patients to the age of 25. As an Adult "X" now fell into the [redacted] Hospital catchment area and the adult mental health services are located in [redacted] a 20km drive away. I believe there should not be a different catchment area for children & adults for mental health services. People with BPD have significant trouble forming relationships at the best of times, and to force them to have to start therapy with a new therapist just because they turn 18 is detrimental to their mental health and set them back in their treatment. **What I would like to see is a review of hospital catchment areas for mental health services so that it is the same for children and adults and some logic used in deciding where the boundaries are – if you are in walking distance to a service you should be in that catchment area, not be made to drive 20km to access services in another catchment area.**

Another major problem we have found is that once "X" turned 18 the hospital emergency ward, medical wards & psychiatric wards allowed her to make decisions about her anorexia treatment. "X" has been allowed to discharge herself against medical advice many, many times. There have been times when "X" was being admitted to the emergency department on a weekly basis for dangerous potassium deficiency & being allowed to leave before her potassium was back to normal levels. "X"'s BMI has been below 13 at times and clearly very unwell, but despite this "X" has been allowed to discharge herself against doctors advice. Numerous research studies have shown that once a persons BMI falls below 15 an anorexics cognitive function is impaired and they can no longer can make logical & wise decisions when it comes to what medical treatment they need. In addition to this issue the anorexia disorder itself fights against the person wanting to get better. One emergency doctor advised me that an anorexic patient organs need to be shutting down before the hospital would over ride the patient's wishes no not have treatment. No wonder we have such high mortality rates with decisions like this. **What I would like to see is a review on how an anorexic patient with impaired cognitive reasoning due to their low BMI is managed. I know there probably isn't an easy solution to this but allowing a very unwell person with a BMI under 13 & the patient informing the doctors that they have no intention of changing their eating behaviors from walking out of the hospital against medical advice IS NOT THE CORRECT SOLUTION.** By the time a person is this unwell they quite often don't care if they die.

Another issue we have come across is that when "X" has been admitted to a hospital ward to be made medically stable, whether caused by her eating disorder such as heart/blood pressure issues, self harm, or a suicide attempt (of which there has been many) or is admitted to a psychiatric ward the hospital staff refuse to also treat her anorexia, so "X" chooses to not eat her meals & continues to lose weight.

When you ask the nurses to please ensure “X” eats her meals, the nurses response is that she isn’t admitted for “anorexia” so it isn’t part of the treatment plan. This has happened EVERY time “X” has been admitted to any hospital ward other than an actual eating disorder ward. I find this lack of ability to co-manage her medical issues **totally unacceptable**. This is like schizophrenic being admitted to a medical ward, and the nurses not ensuring they take their schizophrenic medication. Or a heart attack victim on anti-depression medication admitted to hospital, you treat the heart attack and ensure they are taking their anti-depression medication too. Food and nutrition is an anorexics medication. Just because treating an anorexia is hard doesn’t mean you don’t treat it. **What I would like to see changed is that the eating disorder is not ignored when admitted to any hospital ward, but is co-managed along with her other medical issues.**

I also believe there needs to be access to public funded residential treatment programs for eating disorders. My daughter has now been suffering from her eating disorder for 9 years and she has all but given up hope of ever recovering. From my understanding the most successful treatments have been through residential treatment programs, but as these are all privately funded we have not been able to afford it. Given that eating disorders have the highest mortality rate the public health system really needs to provide greater services for this insidious illness. Offering more medicare funded sessions is a start – but I find it amazing that you have delayed the introduction for 12 months – maybe the people who died in this 12 month wait were not important? I am currently unaware of how the program will work, but it needs to be fully funded by medicare with no out of pocket costs to be really helpful. Eating disorders can take many, many, many years to resolve and many of the patients who have severe eating disorders are on disability pensions so they cannot afford to pay weekly out of pocket medical expenses.

Thank you for reading my submission and I hope my input has an impact on the eventual outcomes.

Kind Regards,

Mother of “X”