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

Organisation Name
N/A

Name
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What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"It is well known that Mental illness can happen to anyone be it genetic issues, environmental or situational issues. Unfortunately, whether it be unemployment, disability or mental illness, the us and them mentality permeates society and until causes of mental illness are revealed such that the others can relate and understand, then such stigma will continue. One of the other great issues that is not being dealt with, is those that are forced to deal with loved ones of those in society with mental illness. The current structure (and have described a meeting with a CEO of a PHN elsewhere) is that much of the medical system is only geared to those with a diagnosed medical condition (be it borderline personality disorder, schizophrenia etc). What I found was that when my parents were close to death, the palliative care unit of the hospital rang me to ensure I was alright. This is in stark contrast to when my spouse was seeing a psychiatrist, I was neither contacted or counselled about how to manage the situation which has resulted in outcomes that were both foreseeable and tragic for my spouse, myself and children. The cloak of confidentiality, seems to be different across various medical conditions and therefore the medical profession is influencing and actively involved in discriminatory practices. The tragic consequences of such medical discrimination are outlined in my book The Pinball Machine The family separation industry and parental alienation by Trevor Cooper. Essentially how a mentally unwell person that had been on medically prescribed mental health drugs as a teenager (and felt dependent up them so never treated successfully), went on to wreak havoc of her spouse and children destroying several others lives and causing mental health problems in those which whom she had a major influence (her family resulting in cPTSD and other issues). It is cases like this that I can see why isolation (in psychiatric units) were historically performed, however a better solution is needed. Concealment of a condition can be counterproductive and should we be treating mental illness different to a physical issue such as a broken arm? If someone breaks an arm we will issue a doctor's certificate telling their employers and loved ones for example that they have broken arms and cannot lift more than kg until the arm repairs however we put mental illness in the cloak of secrecy that compounds issues and often immediate family are not consulted. Does the mental health medical practitioner have a duty of care to those in the community that have contact with their patient and should patient confidentiality reign supreme? I contend that the stigma and discrimination within the medical profession MUST be reviewed and their responsibility to be more than just to their patient. When people do not know what is going on and do not understand how to manage, then discrimination will follow and this statement can also be applied to mental illness. "

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?
"Current treatment paradigms are having some impact or may be worse (particularly in suicide) but has possibly achieved what it can with its current approach meaning that existing system may have reached its maximum utility and further funding may be pointless. A new approach is

required that looks at the root causes of mental health issues and focus NOT on measurement of anxiety but focussing on what is causing that anxiety i.e. the drivers. Understanding of why some people will suffer while others are resilient seems also to be greatly under researched. From a scientific perspective if all your control group is (for example) has Borderline Personality Disorder then you are not studying the population that were put through the same situations and circumstances that did not contract Borderline Personality Disorder and so research is focussed on treatment and not prevention! Research focus and funding needs to change from treatment effectiveness (often drug trials) to establishment of situational assessments and analyse groups who developed the condition and those who were resilient enough to avoid developing the condition. This is nothing new to the medical profession as with diseases like Polio we do inoculation to ensure immunity rather than treatment of those that contract the condition. The current focus on drugs and treatment after the contraction of a condition represents a lost opportunity to change the trend of greater prevalence of mental health! By far one of the greatest issues that has escalated the prevalence of mental illness is what is being perpetrated in society right now. The framework that puts mental illness as a pure medical construct and largely biological to be treated by drugs is a failed paradigm pushed by pharmaceutical companies rather than social construct of which the social drivers need to be managed. I often deal with mothers and fathers that come to me and tell me of their direct experiences. One was a father that visited a primary school to see their teaching. What he witnessed was the class being segregated into boys and girls, the girls taught to protect their bodies from boys and the boys told that they were not to grow up to abuse women and made to do an affirmation that they would not and to be ashamed of being boys. This was done under the guise of respectful relationships. What was meant to be a system of mutual respect in relationships had been perverted into girls are good and victims and boys are inherently bad. It was so overt, what this parent witnessed that those that have perverted the program of teaching mutual respect need to be considered a major cause of future mental health and suicides. The dynamics of how this effects boys and I believe girls as well is best described in the book The Boy Crisis: Why our boys are struggling and what we can do about it by Warren Farrell Phd and John Gray Phd. "

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

"The GP Mental Health Plan has helped many people when a suitable provider is found. There is however a major obstacle to people getting help through the system when going through a toxic family separation due to the standard legal tactics associated in divorce which is responsible for many deaths. I have never had problems overcoming this obstacle of getting people into the system using the tactics described in the book The Pinball Machine The Family Separation Industry and Parental Alienation ISBN 978-1-925935-18-9 & 978-1-925935-19-6 chapter 9 (which is due for release shortly). What is working exceptionally poorly is funding allocation being proportional to the demographics of those that complete suicide and the causes. By example: Suicide Prevention Australia (the peak body that represents its members in the sector) has lost its way in the politically correct era that we live in. This is evident by recent conference schedules which focus on three areas being LGBTI, Women and Aboriginal and give a very small proportion of their conference time allocated to men (which are 75% of the successful suicides) and then, when you look at the subjects are topics like toxic masculinity. This is effectively demonising the largest population that completes suicide and does not do anything to address the issues they face. Such a refocus is essential and more likely to reduce the suicide rates. Part of the major problem with conferences like this is that academics researchers are required to present their findings and suspect the bias of papers in funding research are associated to other areas than male suicide. Governments (through the public service) are ensuring funding is not being spent

where the needs are greatest. If Australian population is 100% and the number of those identifying as Aboriginal is 3% yet they represent 6% of the nation's suicides (note these figures were derived from some articles on the subject which may be inaccurate) then I would propose Aboriginal focus receive 6% of the funding. Anything more takes resources away from where the largest target population of suicide exists. A meeting with a CEO of one PHN revealed that 50% of those going through gender transition surgery in this PHN area completed suicide and therefore needs to be addressed and was clearly her priority. What she planned, be it cancellation of all gender transition surgeries (under the premis of primum non nocere or first do not harm) or alternate psychological assessment I am unaware. When it came to male suicides which are far greater in volume she understood what was going on following family breakup and stated that We cannot do anything until they are registered and diagnosed the medical practitioner. What this demonstrated was a total lack of willingness to reach outside the PHN network of registered doctors and psychologists etc to the very people that they need to reach and deal with the potential suicide candidates. The PHN system is therefore failing to address the crisis of suicide, fundamentally failed in its Duty of Care and should be culturally changed or disbanded as appear to do little that Is not centrally managed and directed. Note that there should be some reserve for emergency funding as we do not want a single suicide in a school turning into a suicide cluster however this should be able to be managed by keeping 10% of the total funding available for discretionary focus and reported back to parliament. In other words, a more rigid structure of accountability for funding in both research and service delivery to target the correct demographic is required. "

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.

"This sub statement indicates this is clearly the wrong question and directed towards getting treatment! What this question shows is that this Royal Commission has been framed by vested interests to secure greater funding for their profession and grow their profession and industry at taxpayers' expense rather than focus on prevention and shrink the need for this industry. There is also enormous variation in the capabilities and results of various providers. Some will NEVER cure their patients resulting in a regular source of income. Others cure their patients and have a greater turnover of clients. I particularly see this when it comes to situational distress. Those that have been through the situation and are also qualified with helping people work through their issues are great but are extremely rare. As such, sending someone to a generalist psychologist or counsellor when the root cause is that they are suffering from a family breakup (made difficult often because the other party has a mental health issue) can be counterproductive as often just given drugs and some coping strategies but never dealing with what is causing the stress. Matching the right psychologist is essential in this area, yet this is not formally done! Similarly, sending a city psychologist to meet with a 3rd generation dairy farmer and convincing him that he will go bankrupt if continues and need to do something else would probably result in poor outcomes! "

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

"The mental health industry itself is a major contributor to the dramatic rise in mental health as is the government policies that I have outlined elsewhere in this submission. A paradigm shift needs to be made away from treatment to prevention and the situational determinants. I sat on a panel that was designing a web based tool that essentially measured anxiety indicators and pushed people into mental health providers and never once asked what was causing the anxiety! The web

based tool was therefore geared towards attracting customers regardless of what was going on in their life. This is addressed to some extent by the paper by Western Sydney University https://onetreeaustralia.org/wp-content/uploads/2018/10/Situational-Approach-Document_web.pdf And https://onetreeaustralia.org/wp-content/uploads/2018/10/Mental_Health_Literacy_Paper_web.pdf and the causes of suicide and treatment were discussed in a news article https://www.news.com.au/lifestyle/health/preventing-suicide-the-basic-mistake-holding-us-back/news-story/c1735d0d4139443c3fa2be5983efd9a6 What the mental health industry has developed is extensive referral networks (some are essential) into its network of mental health professionals and disempowered the communities at large. Peer support has been pushed to one side rather than seen as an integral part of the solution. When peer support is embraced by Australian Health Network is appears to be in a way that will ensure its failure when I consider the research paper Peer support in adult mental health services: A metasynthesis of qualitative findings. and be the first area reduced in the inevitable budget cut cycles. They have also ensured huge and unnecessary educational barriers to entry by Peer Support workers with extensive courses (clearly influenced by the education sector that wanted their share of the pie) rather than what is essential and extensive work experience (that they would not be paid for). As such, the use of peer support has been approached much like an episode of Yes Minister where they enter into something to ensure they can prevent and destroy it! My personal experience is that peer support is a critical area for those suffering mental health issues (particularly in the area of situational distress) and this was echoed in the inaugural speech of Tony Gee (Compassionate Friends) gave this talk at the Launch of the Charter for Peer Support and the Centre for Excellence in Peer Support on 21 June 2011 "

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

This has already been discussed elsewhere when addressing other questions. Until the stigma and associated confidentiality are addressed then problems are likely to simply get worse!

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

I have largely addressed the issue of peer support workers in a different question. Peer support workers should not be embedded into the existing health infrastructure and a completely separate organisation based upon community development principles is required. I have such a proposal available and was submitted to some MP's some time ago.

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

"For decades employment subsidies have assisted in many area's such as workforce reintegration after prolonged unemployment, these however, have always been piecemeal and often short lived. The same goes for people with disabilities and I am informed that historically the specialist education of blind people had a success rate of around 80% placement into employment however this has dropped to around 30% since integration policies within the mainstream education system have been imposed around 30 years ago. First and foremost, a strong economy and low rates of underemployment will ensure employers look at ways to employ the less than ideal candidates and bring greater flexibility to the workforce. The levels of confidentiality and risk means that a suspicion of risk, will prevent people with certain mental health conditions being hired. Such was

the advice I received from a government funded organisation as outlined in my book The Pinball Machine, The Family Separation Industry and Parental Alienation however I ignored the advice and secured meaningful work."

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
A new organisation for suicide prevention focussed upon peer support that is separate from the existing health services is desperately needed. While this may often channel people into existing services it must be independent rather than a subsidiary which would be forced to push people into their existing inappropriate in many cases structures.

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
Covered in other questions.

Is there anything else you would like to share with the Royal Commission?
"As stated recently by the National Mental Health Commission and echoed by Suicide Prevention Australia, focussing on Mental Health (owned by a Health Minster) is counterproductive and we need a whole of government approach. Decisions by government should consider the wellbeing of the population rather than pure and short-term economics. Furthermore, the current craziness in political correctness and domestic violence programs which have achieved no measurable benefit and I see lots of evidence to show they are fundamentally flawed, are damaging in terms of mental health and suicide. A new ministry for Men and boys as currently being advocated by Warren Farrell from his book The Boy Crisis: Why our boys are struggling and what we can do about it by Warren Farrell Phd and John Gray Phd and outlined in the Video https://www.youtube.com/watch?v=8vX6345eeq4&feature=youtu.be will be an important development to avoid what will otherwise undoubtedly be a massive increase in issues over the coming decades."