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

Organisation Name
N/A

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What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"Stopping the brutal apprehension and compulsory treatment especially with disabling and suicidal introducing drug trials of abused people, particularly elderly women, abused by family and patriarchal legal, policing, medical and even churches to cover-up, ridicule, and silence victims of oft repeated abuse, plus the consequent fear and disabling of stigma, discrimination, and oft decades of scapegoating! Decriminalizing victims of a medical system which has no association, or real record of what is health in terms of the WHO or person. Waste of money on the kudos of drug running professionals particularly in the public system and apprehension of elderly and isolated women as easy clients to fill beds of justify funding. "

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?
"I think if each medical clinic as the most accessible and available venue in each community run facilitated discussion groups that encourage the discussion of quickly changing community and individual realities, and sharing of thoughts and experiences in relation to health (in the widest WHO sense). Stop the power games between the acute, oft criminalizing hospital treatment, and make it accountable for the results of its portion of the mental, and health budget, in relation to long term monitored individual and community outcomes. Ensuring that chosen non drug treatments, the confrontation of abusers, and preceding traumas are addressed before individuals are disabled and re-victimized."

What is already working well and what can be done better to prevent suicide?
"I think if each medical clinic as the most accessible and available venue in each community run facilitated discussion groups that encourage the discussion of quickly changing community and individual realities, and sharing of thoughts and experiences in relation to health (in the widest WHO sense). Stop the power games between the acute, oft criminalizing hospital treatment, and make it accountable for the results of its portion of the mental, and health budget, in relation to long term monitored individual and community outcomes. Ensuring that chosen non drug treatments, the confrontation of abusers, and preceding traumas are addressed before individuals are disabled and re-victimized."

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.
"Having a medical system rather than a health system. As previously suggested health in community needs to be addressed in facilitated groups in medical clinics in each community; all other associated services could input into these and the regional hospitals, schools and universities. The latter should involve multi-stream student experience and input, plus major data

collecting, collating, and research."

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
"De-medicalization of our frightening, disabling, pharmaceutically built system in which public hospital and compulsory clients are the prized research victims. Hopefully, the Royal Commission, plus good will in many areas, and the facilitated groups mentioned above will help find strategies to turn around the steep decline in health in Victoria, Australia and worldwide over the last three decades"

What are the needs of family members and carers and what can be done better to support them?
"Destigmatizing the system. Making it easier and less costly to get help. Again, having facilitated groups in each medical clinics. Addressing the needs of the family for support, and taking action to confront abusive or non-appropriate behavior. Making medical and professional services accountable for enhanced health outcomes rather than drugging, silencing, and disabling for temporary respite!"

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
"Formation of a mental health workforce rather than a medical, acute hospital system that is pharmaceutically driven medical mental illness specialized and focused principally on some chemical imbalance."

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?
Enabling people with mental health issues that involves us all to be welcome members in the facilitated groups mentioned above. Run weekly in each clinic these would quickly identify needs and opportunities.

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?
"It should look like a highly prized community health system that truly meets WHO criteria as discussed in facilitated groups as suggested. Appropriately funded for initially one or more local clinics these could quickly raise interest and excitement in understanding concepts, identifying issues, and supporting needed health service access and outcomes, monitored by the community and added to regional data bases. "

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
"Hopefully the work that is going into the Royal Commission and the wide publication and discussion of results in media programs such as Insight. Maybe ongoing community discussions and follow ups to the RCVMH consultations three monthly to discuss what's happening and further input or suggestions. From personal experience and hearsay there was minimal input from sufferers of mental ill-health in the community consultations, which could threaten the success of healing a broken system. I believe it is essential local facilitated groups and regional groups get

started quickly and are advertised widely. These would empower and best use the resources, goodwill, and energy of all interested; and, perhaps stimulate sizable, healing and active community."

Is there anything else you would like to share with the Royal Commission?
"Yes! There seemed to be little input to the community consultations re-the elderly, many that have suffered a lifetime of abusive incidents oft justified by the mental health system and disabling the victim with lifetime stigma and drugs, often leading to their admission to a nursing home, and a mental illness record that acutely acts as as barrier to getting timely acute and follow-up health orientated care for a stroke or heart attack. Elderly abuse is increasingly common, as is the stress of the person that is pressured to care. As the elderly cover an increasing age range, on the edge of quickly changing demographics and realities, oft living with post-traumatic and unhealthy incidences of a lifetime. Moreover, it is an age range not experience except by the increasingly lucky professional. Further, where our First Peoples are getting belated recognition for the considerable work and importance to their community, likewise some multi cultural elderly, others are increasingly isolated and without, or little, family support."

SUBMISSION TO THE ROYAL COMMISSION MENTAL HEALTH SYSTEM

I am a 76year old female at present on a compulsory community order, following a long, three months, spell in hospital over Christmas 2018; and a consequential slide into suicidal hell due to the trial of numerous drugs and their life and health destroying side effects.

I was blest to attend six community sessions of the Royal Commission into Victoria's Mental Health System in Melbourne, plus two in Boxhill, and two in Bendigo. I found it a wonderfully healing to be heard, and to hear so many sad stories, all shared with the hope of mending our `broken system.' The irony is, historically it has never been whole; or anything we can be proud of. Yet even in my personal experience, there have been improvements, especially post the handing down of the Victorian Mental Health Laws 2014. However, in practice, these are not necessarily followed; and those who are battered, heavily drugged, fearful, and with a reduced individual sense of self and dignity cannot even see through the changing fog and storms to complain?

Sadly, in the sessions I attended, I was alone in speaking up for the elderly: an increasingly vulnerable, oft rejected, abused, and isolated demographic on the edge of a stressed and rapidly changing world. How sad it is hear, at last, only our Indigenous Elders recognized and honored for their most significant community roles. In contrast, out of the workforce, we, non-Aboriginal are just lucky money spenders - maybe: and maybe with time to volunteer, even using our lifetime of learning; otherwise we are seen as an increasing burden when no longer caring for the grandchildren.

Yet we cover an age range equal to generations X, Y & Z. There is a great different between individuals born before or in WW11 and the baby boomers. The latter are generally closer to the small `lucky Australian' nuclear family, professional and technological worlds of today. They are oft naturally more assertive, and have partners and family keen to advocate for them. In contrast, having worked hard primarily to build home and raise children and gain a foothold of a career, the older woman in particular often has her whole home and social life - plus spirit - destroyed by what is oft a brutal apprehension, followed by drugging into submission. Sadly, life suddenly ends in a nursing home!

However, I do see positive change and people working very hard and with professional compassion. Oh! There's the rub! In my experience, that professional compassion automatically compartmentalizes and generalizes an elderly individual to the limited personal experience and perspective of the recently trained professional; and a career based in a particular educational era and place; moreover, all reduced to fit the documented reality of the psychiatrist in charge. Sadly, this leads to documented innuendos, misinterpretations, mistakes, and lies. These mount with daily reports, medical visits, and even with visitors apprehended on their way! Moreover, they mount and mushroom from treatment to treatment, especially involuntary treatment, justifying drug trials. Such circumstances gift me a health history comprising virtually only an A4 list of different psychiatric diagnoses following noted domestic violence. It puts a life stigmatizing and life disabling cover over consequent admissions due to a criminally exploitive lawyer and others, justifying and covering abuse up. This is never mentioned; nor is the violence or any background reality addressed. Indeed, in my experience, the mental health system is frequently the last arm of abuse for domestic and institutional violence. It is used to silence, disable, ridicule any complaint, and humiliate victims.

I mention two recent incidences of these `mistakes'. Firstly, the reality that my then GP's record of health treatment was a A4 page of dated psychiatric diagnoses, plus hypertension with no date of commencement. It also stated I had a tubal ligation 2015: that is at 72!

Besides the gross and demeaning statements giving reasons for my recent incarceration,
Shoplifting
Handing out bags of cash – I am a very careful spending pensioner

Calling in the British army
Statements, I say are completely untrue, life demeaning and stem from the same GP's need to cover up abuse,

a new disabling mistake is added to the permanency of a life incriminating record.

This adds to psychiatric drug side effects, plus transfer to acute situation and consequent urinary infection, leading to three months as a hospital `victim.' On three occasions hospital admission has led to destruction of my previous fit and active life, and into dangerous suicidal hell. Hence my need for the Community Intensive Care team. Among other disabling side effects of enforced treatment, I took two soluble Apros, on two nights, for a sore throat. Next morning, I had five huge bruises. My local GP put these down to the Aspro; although I've taken Aspro in the past. Never the less, on the transfer form from the Intensive Care Team, I was actually been recorded as taking Aspro mane!

One of the reasons for involuntary treatment is danger to life of self or other. My experience is that neither have been true until post hospital, when on several occasions I have been reduced to be dangerously suicidal and grossly depressed for months: naturally earning me more labels as a voluntary client desperate for help!

Moreover, instead of getting any history, or talking to the patient before getting them submissive and self-less, every different professional goes on `statements' of numerous players and hospitals, and the individual reports of each of many staff members. Furthermore, from any individual family members available, no matter how stressed they are, or if violence is a reality. They are abducted on the way to visit and told any tale to make them the responsible carer needed to answer discharge demands. Even when it is known domestic or institutional violence is behind, or part of the reason for, admission; and in spite of frequent requests for support in handling background issues that so-called treatment justifies and multiplies. The result is likely to be an added diagnosis of paranoia and an increase in drugs!

Another aspect that I believe leads to a diagnosis of mental illness in the elderly is, in some communities, the absence of nearby meeting places where one can meet others, have a drink, and sit and talk. On the other hand, in extended care units, I feel much would be gained in empowering clients and breaking down isolation by facilitated sharing and discussion groups. There needs to be more than time occupying art groups that are elementary to many women with a lifelong curriculum of creative pursuits. On the contrary men may be expert at woodwork and other handyman crafts. Of course, these are not available; however, they may enjoy new and simpler artistic experience. Sadly, in any case, focused activity such as coloring in, can actually stop or prevent conversation.

To conclude, I agree the system remains broken; and I hope the Royal Commission leads to enlightenment, and a true Mental Health Service. One that is not purely medically driven, drug pushing! It is my experience that the huge expenditure that goes to the acute medical system causes life stigmas, disablement, victimization and silencing of victims of oft multiple abuse. This allows no dignity or human rights. Sadly, as we heard, this money is desperately needed in the community.

Fear and deep post traumatic realities increase vulnerability to, and from much psychiatric treatment. This fear, for me, is raised by the reality if I had a stroke or heart attack, psychiatric treatment is likely to impede recovery, sadly leading a previously extremely fit and active person to be prematurely admitted to a nursing home.

Thank you so much for your work, the opportunity for personal input, and the excellent community meetings,

Maureen Garrett