SUBMISSION TO THE ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

ODYSSEY HOUSE VICTORIA

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About Odyssey House Victoria

Odyssey House Victoria (OHV) is a specialist alcohol and drug treatment service delivering innovative programs across Victoria to children, youth, adults and families. We are place of hope and positive change for individuals working towards breaking their pattern of addiction. At OHV we believe that every person should have the opportunity to change and grow. Our diverse teams work with individuals, families and communities to reduce drug use, improve mental health and reconnect people to their family and the community. In 2019-20 we worked with more than 16,000 Victorians.

Context of these responses

Ten senior staff and representatives from each of the major OHV programs met to discuss their responses to the Mental Health Royal Commission questions after those questions had been sent via e-mail to all staff in the organisation. Some clients were also invited to share their experiences. Responses focused on people with a dual diagnosis or those experiencing both mental health and alcohol and other drug problems.

Odyssey House staff and clients also provided input into other submissions such as the one from VAADA.

AOD (Alcohol and Other Drug) and MH (Mental Health) will be used in some instances in this submission.

Odyssey House Victoria's services are informed by a bio-psycho-social approach. In our experience with mental health and alcohol and other drug issues, the social aspect of treatment and recovery do not receive enough attention or emphasis.

With the exception of some pharmacotherapy providers, the AOD sector has maintained some integration of medical/clinical and psycho-social services. The integration of these in MH offer appears to be a barrier for coordinated care.

Odyssey House is supportive of better resourced, and better integrated, MH and AOD sectors, who both have greater capacity to support those with AOD and MH problems. We do not recommend merging the MH and AOD sectors, or having either sector manage the other as a whole, due to important differences in approaches and skills that are important success factors for positive outcomes.

Integration within a provider of services, across providers of services, or at a local geographic level can be achieved and will provide better care with superior outcomes.

Voices of people accessing Odyssey House services about their treatment in MH services

31 years old male

"They need thorough assessments. I was given heavy medication at a psych ward that I didn't need. They need more professional staff who know more about mental health and they need services which aren't part of a normal hospital, it needs to be separate."

26 years old female

"I've always felt like I've had really good treatment at a psych hospital. I've never felt judged. I felt respected and like I had options about treatment."

26 years old male

"*I admitted myself into a psych ward and felt like if I didn't leave after 5 days I was going to get worse. The environment was toxic for me and I was targeted by another patient on the floor. I felt unsafe and didn't feel supported by staff. Basically, unsafe behaviours by other patients weren't managed well. It was a hard time in my life and I felt like I was left to fend on my own."*

46 years old female

"*I had a counsellor for 2 years who saved my life, it was awesome. I felt safe and I trusted her. She supported me at court. It was great that she could come with me because she heard what happened and supported me afterwards. The service closed down suddenly and my appointments just stopped. I went really bad after that."*

54 years old male

"I only had 12 sessions with a mental health plan which wasn't enough. Another time I was seeing someone who was really good for around 9 months but he just left. I remember feeling lost and alone."

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

If someone has co-occurring mental illness and substance use, they are doubly stigmatised with some in the community seeing them as both 'mad AND bad'. Stigma is made worse by the punitive/inappropriate use of language.

Recommendations

- Education campaign for the general public should include:
  - What people can do for someone who has a mental illness (or co-occurring mental illness and substance use issue).
  - Guidelines for media reporting on both AOD and MH have been developed and should be promoted.
  - That co-occurring drug use is usually about people coping as best they can
  - To be careful how they use language. Separate the issue from the person. 'The mentally ill' or 'addict' or 'a drug user' ignores everything else about that person. Recommend this is strongly reinforced in the media. Describes behaviours rather than identifying people as their problem/illness.

2. 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?

Treatment for chronic mental health is not properly funded. NEAMI was good but it was reduced as a result of NDIS implementation. NDIS operates with the expectation that people are able to self-manage or have an appropriate advocate and many people living with mental illness do not meet criteria for a NDIS package. Medicare rebate-able psychological treatment assists people in need to get treatment but the limitations on the number of treatments are restrictive.

Stepped care based on diagnosis works well but it is regionally determined, so some areas deliver better care than others. All the ATAPs is now stepped care (also suicide intervention) all with their own names e.g. Care in Minds which is confusing for clients. Consistently high-risk patients are case managed which is necessary and valuable, however accessing that service is very difficult.

Mental Health Alliance meetings work well but under-resourced organisations find it difficult to attend these regularly.

There are insufficient mental health services for people in growth corridor areas of Melbourne and in regional areas.

People with mental health issues, that do not meet thresholds for tertiary services, are regularly being managed in under-resourced AOD services. Some dedicate resources for this group would significantly and very efficiently enhance their care in the AOD system.

Recommendation:

- Expand funding for outreach community mental health and case management to support chronic mental illness to prevent escalation and crisis. That is, improve the psycho-social MH support to people with need who are not eligible for NDIS.
- Increase the number of Medicare-rebate-able treatment sessions for people diagnosed with chronic mental illness to see psychologists/registered mental health clinicians.

- Provide dedicated resources within AOD services to better manage people who are not eligible for tertiary services.
- Provide easier access to secondary MH consultation and assessment for staff in other sectors to access, so they can better support the MH of their clients.
- Improve GP responses in managing psychopharmacology. In particular:
    - Over-prescription of antidepressants
    - Lack of medication reviews
    - Lack of understanding about access to primary mental health services.
    - Clients previously and loosely diagnosed with mental health conditions by GPs without comprehensive testing

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

Applied Suicide Intervention Skills Training (ASIST) & Mental Health First Aid work well to educate staff and students in AOD. It also means people are less scared to ask about suicide and events such as RU OK make it easier to speak about suicide to friends.

It works well if AOD admissions rings CATT and CATT come out to do a risk assessment rather that the client going to hospital emergency departments.

Suicide treatment is poorly managed in Victoria. There are limited options for people at high risk of suicide: currently the options are hospital emergency departments, call the ambulance or the Crisis Assessment and Treatment Teams (CATT). Long waits for all are the norm; if the person makes it to hospital, usually they are observed for 4 hours then sent home. There is rarely any follow up. If calling the CATT team, a worker can wait up to two hours for CATT then the call will drop out. If you succeed in getting through and they say call the ambulance who then tell you the person is low priority. There needs to be a less time-consuming response.

In hospital settings much time is taken up with paperwork and legalities; no one has time to talk to patients. A group would be great but there's no time. Consequently, people act out and those around them are re-traumatised.

This is more difficult still if the client is substance affected; the service will try to keep the client there to 'dry them out' for a while and sometimes will not progress to a mental health assessment because of intoxication.

There is a distinct lack of MH treatment available once the immediate crisis has passed, and early intervention responses are not readily available.

There is no follow up for noncompliance with discharge medications or ensuring that the person makes contact with their GP. There is no check-up after a hospital emergency department discharge for suicide risk.

Recommendations

- Segregate hospital emergency departments (ER) into separate areas for physical issues and mental illness, especially suicidal behaviour and psychosis. Have mental health clinicians rostered on to triage quickly.
- Have repeated **proactive follow up** for anyone presenting to ER with mental illness and/or suicidality and link them into case management.

- Increase community mental health services for people with borderline personality disorder. There is often confusion with behaviour branded borderline rather than recognising it as suicidal.
- Do not automatically provide a police response to a mental illness-related ambulance or CATT request, as this can increase distress and risk for clients and family.
- Increase the availability of mental health Nurse Practitioners to reduce the pressure on GPs and psychiatrists for psychiatric triage.
- Trauma Informed care education for mental health workers.
- Create same-brand mental health service hubs across the greater metropolitan region to provide hope to clients. These would be places where people living with a mental health issue can go and feel it is a safe environment. In addition, clients need help to get there.

4. **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.**

Chronic mental illness

The focus of psychiatric services is currently on symptomatic management of severe presentations rather than looking at the whole continuum. Would like services that assist people to manage the condition over their lifetime and more recovery oriented care.

There is a cohort of people who live with chronic illness and addiction, but who do not meet the threshold for acute services. Their experience of treatment is of episodic responses: they manage as well as they are able until they experience an acute episode of mental illness, putting them at risk to themselves or others. This enables them to meed threshold for acute care. In the meantime, there are many harms that occur – running up debts, losing jobs, losing houses, damaging relationships. When they hit that threshold, their mental health is much worse than if there was earlier intervention and follow up is poor after an acute episode.

Many clients use AOD to manage their mental health and as a result face a double stigma from this form of coping/self-medicating.

Private systems are difficult to get in to and costly. Private systems generally do not want to work with clients who have more severe AOD issues. GPs and psychiatrists are small businesses. Such clients are disruptive and complex. Mental Health Treatment plans are currently used as a dumping ground for complex clients. They offer a limited number of sessions per year.

There is a dearth of psychiatrists in the public system that work in this space. Unless you add more resources in the chronic end, you end up spending a lot more in crisis interventions to the detriment of the person.

AOD staff can more easily work with people with both a MH and AOD issue when the MH issue is stabilised. It can be very difficult accessing MH expertise in order to achieve this.

Meaningful activities and connections

A sense of connection and meaningful activities are essential for mental well-being. This is particularly true for people with mental illness who are often socially isolated, because of stigma, particularly if they have dual diagnosis. AA and other groups are difficult if you are the only one with a current dual diagnosis.

Positive, pro-social and respectful relationships are key to someone's recovery from AOD and MH. Programs need to support people to learn the skills to better manage their emotions and their relationships to create long-lasting and meaningful connections.

Other

Finance and Housing are the two biggest issues that complicate well-being for people with chronic mental illness.

When people are jailed their CTO ceases to exist, so they are no longer required to take their medication or have Depos. Most are immediately taken off their medication - anti depressants, anti-anxiety, anti-psychotics with consequent deterioration in mental health. People released from custody won't have their medication or their discharge summary. They will send the person to the ED psych registrar or provide them with 3-day script with pharmacotherapy. This is insufficient and inefficient care. There needs to be proactive follow up.

People are often immediately placed on medications (with no alternatives offered) and then don't comply with them. People stay on medications for years and it's never reviewed. If they are hospitalised, when they are discharged they are given medication but may not have a GP to follow up on their medication. Or the GP makes their own decisions and changes what the hospital did without checking in with why this decision was made.

Older people often inadvertently engage in polypharmacy resulting in overdoses. This is a result of poor memory and changing doctors.

Recommendations

- Increased resources for chronic, non-crisis mental illnesses intervention to support clients to manage their own mental health and engage in meaningful activities.
- A focus on safe, supported housing options for people living with chronic mental illness.
- Proactive follow up and case management for all clients identified with chronic relapsing mental health issues across all systems with particular reference to the forensic sector.
- Greater collaboration required between mental health services and
  - dual diagnosis nurses in hospital
  - other health practitioners when organising care plan meetings to support improved outcomes for people with mental illness.

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

CALD

Intersectionality is a significant complicating factor and does not tend to increase prioritisation of treatment.

Lack of education is a factor for some communities who have a culturally defined idea of what a mental illness is. For some refugees, having a mental health diagnosis may mean they or their affected family member cannot stay in the country. For others mental illness is considered shameful.

Lack of knowledge that what they are experiencing is mental illness and not bad behaviour. Many are still scared to talk about it.

Mental health clinicians must consider cultural issues with some communities who often hide mental illness or have different beliefs in what a mental illness is/means. Community education

about mental illness targeting these communities to address stigma may assist. There can be hidden issues relating to citizenship and health care which can lead to families hiding MH issues

Other than e.g. Vietnamese women's association, for CALD communities, there are often few options for those with limited/no English – recommend a program for accessing interpreters e.g. for private psychologists

Highly traumatised refugees from war torn countries on drugs are dangerous and our responses to them are very poor.

Rural

Few resources in country areas – it's expensive to get help. People have to get to a serious level of crisis. There are not enough GPs/mental health workers in rural areas. They sent newbies or inexperienced overseas trained GPs to rural areas.

Lack of housing exacerbates mental health issues. In rural sector there are no services for the homeless.

Aboriginal

Mental health services need to consider culturally appropriate services to make it easier for Aboriginal clients to attend.

Youth

The MACNI panel has noted there are not sufficient residential youth AOD/mental health programs where people can be safely held. Voluntary Youth programs work for some, but secure facilities are needed for others. Secure Welfare is not an effective alternative. It is short-term, with consulting staff, and will always struggle to be therapeutic as a result. Because there is nothing for youth, hundreds of thousands of dollars are spent to rent a house for one client with two workers providing 24/7 monitoring. There's Thomas Embling for adults. Some of the clients there could have avoided going there with some basic intervention.

Other

Focus on communities of interest: GLBTIQ, CALD, Asylum Seekers, Aboriginal; mental health issues in an aging population.

There is a disconnect with the criminal justice system and mental health services particularly with medication use. People are discharged from prison with limited medication support and are expected to make the connection with a GP themselves. There is no proactive follow up. People often slide directly back into drug use to self-medicate. Overdose is a very real risk.

Recommendations

- Proactive follow up of clients with mental illness and/or histories of drug misuse post prison release. Consider incentives/contingencies to motivate compliance.
- Education campaigns for specific cultures in relevant languages that target community leaders (perhaps using peer workers as ambassadors), when that culture has a particular unhelpful belief about what a mental illness is.
- Increased telehealth facilities in rural areas and providing nurse practitioners/nurses to support GP Skype sessions as some patients with mental illness and their families will struggle with a Skype interaction without a facilitator.
- Mental Health clinicians to be trained in trauma-based care and how it impacts on mental health.

- A youth specific AOD and MH secure facility needs to be developed based on the model that Magistrate Jenny Bowles is advocating for.

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

Families who have a family member with a chronic mental health issue – particularly if that person is young - experience low well-being and poor quality of life. The mental health issue impacts on the whole family, yet family is the most important support to that young person.

On one occasion the CATT did follow up with a call with the family an hour later **and** the following day to see how the person was going. This was great for the family to know someone else was involved.

Odyssey House operated the "Family Eclipse" program for young people experiencing both MH and AOD issues and their families. A Deakin University evaluation showed very positive outcomes for young people and their families, with substantial improvements in communication, relationships and wellbeing, which returned to population levels or above.

Recommendations

- A 24/7 phone service or online/smart phone service staffed by mental health workers for family to call if they need advice. This would be very reassuring and would take pressure off the CAT teams who are often unable to respond in a timely manner or do not attend, leaving the family with no support and no idea what to do.
- Offer discounts and incentives that support the well-being of families who have someone living with mental illness. Have mental health service hubs advertising services and self-care opportunities for families.
- Psychoeducation for the family so they understand what the young person is dealing with is important. Recommend the Traffic light system for people with chronic mental illness: Green - When I am well I look like this; this is what I do; this is what helps. Orange - This is what it looks like when I am not doing well, this is what I need to do. Red - This is what it looks like when things are bad and I need help. There can be a parallel version for families – When she is not doing well, this is what it looks like, this is what I can support her to do, etc.
- Greater support for family-based programs and interventions, that have substantial knowledge and skills to work across both MH and AOD is needed.

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

Nurses and other clinicians have high caseloads in clinical mental health services e.g. 710 patients for one psych registrar. Currently mental health services are understaffed and overburdened.

Looking at it from an AOD sector perspective, it appears that the mental health sector did not take up the *No Wrong Door* approach in any meaningful or sustained way. AOD assessment or screening is not routine, and AOD competencies for mental health staff would enable them to better assess and manage dual diagnosis and increase their effectiveness at work.

Some "Integrated MH & AOD Intake Systems" pay very little attention to AOD issues, and staff lack confidence or training to properly screen for AOD issues. Assessments provided by some of these services are overly medical, and provide inappropriate recommendations for AOD treatment.

Peer support staff need professional development, support, career pathways, and protection from discrimination. This is starting to happen in the AOD sector. It creates career pathways and increased career satisfaction as well as protecting from burnout.

People with a lived experience of AOD issues and recovery are recognised and welcomed across many positions at many levels in the AOD sector, and are not simply restricted to "Peer Worker" roles.

Recommendations

- Consider separating people with acute mental health issues from people with serious physical health issues in hospital emergency departments. This is likely to result in better outcomes for both staff and patients.
- Improve client-staff ratios.
- Provide mentoring, professional development and a broader range of career pathways for Peer Support workers and others with a lived experience of MH and recovery.
- Create incentives for rotations of the clinical workforce in rural and regional communities & outer urban areas.

8. 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?

Responsive employment services are needed. Currently the response is patchy and dependent on the area the person lives in. People should not need to be on Newstart if they have a formal diagnosis and become mentally unwell.

PHaMS (personal helpers and mentors program) and PIR (partners in recovery) has been severely impacted by the NDIS which does not adequately replace what has been lost.

AOD & mental health are not sending our full assessments to each other. This is an area where the new information sharing schemes could help, beyond family violence and child protection issues.

Recommendations

- Provide an alternative to Newstart and additional support/case management for clients with a formal diagnosis of a significant mental health diagnosis who are unemployed but who do not meet criteria for a disability pension.
- Provide mental health training for staff working in employment services.
- Providing free gym passes and other health-enhancement and socially oriented services during business hours to people who have a significant mental health issue and employ people who could assist clients to take them there and get them started. Increase the focus on social outings.
- Draw attention to enhanced outcomes delivered through better sharing of information and integration of AOD and MH services.

9. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

Currently in hospital emergency services, physical health issues seem to take priority over mental illness. If there has been an event, such as a traffic accident, the client can sit there for hours.

If someone presents with what appears to be a drug induced psychosis, treatment is provided with the assumption the psychosis will improve when their drug use stops yet this may not be the case. If someone shows up intoxicated, the mental health clinicians should assess them after they have had time for the intoxication to wear off; do not just let them leave without assessment, brief interventions and supported referrals.

Supported Residential Services for people with mental health issues are currently functioning more like rooming houses.

Recommendations

- Increased support for early intervention and for all stages of a chronic mental health issue (rather than just the acute phase). There is little available for people who find it difficult to cope with living in the community but who are not unwell enough for psychiatric services. Prioritise those not acutely at risk to self or others but who are past early intervention; a response is needed for them and in particular for those clients who have concurrent alcohol and other drug issues.
- Clinicians working in mental health services and in hospital emergency departments are trauma informed and trained in both AOD and MH assessment and treatment.
- Emergency Departments are divided into mental health issues and physical health issues.
- Increase in Mental Health Prevention and Recovery Care services (short-term residential treatment services) and Community Care Units.
- Increase the focus on early intervention and prevention.
- Address bias in the treatment of borderline personality disorder.
- Improve responses for people who have chronic mental health conditions that support them to understand and self-manage their condition. The focus needs to be on the continuum of their mental health issue – not the acute/crisis presentation
- AOD use or addiction should not be a barrier for people accessing support within the MH sector.
- Increase housing and provide greater financial support for people with mental health issues.
- Increase service options and mental health rotations in rural and remote areas to address lack of services.

10. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

In the current system, mental health responses are heavily weighted toward acute presentations rather than supporting clients with chronic mental health conditions. Increased support for chronic mental health conditions, will reduce escalation to crisis and consequently reduce future presentations in crisis services. This will enhance quality of life and increase employability and engagement in the community.

The Victorian Dual Diagnosis Initiative was effective in building dual diagnosis capacity building in the drug and alcohol sector which reduced the number of clients ricocheting between mental health and

AOD treatment services. Instead less serious mental health issues were effectively managed within AOD services with better results outcomes for both conditions. Federally funded capacity building (for the AOD sector) was not equally reciprocated in MH service s. The '*No Wrong Door*' model does not appear to be working in mental health services, due to lack of capacity and the need to prioritise some people over others.

Recommendations

- Recommend a VDDI for the mental health sector to enhance the treatment of alcohol and drug misuse in mental health services.
- Decrease client levels so mental health staff have time to spend with clients to build rapport.
- Provide system navigators/advocates for clients, particularly those impacted by intersectionality (co-occurring illness, cultural difference, domestic violence, etc).
- Align Federal and State mental health systems.
- Focus on mental wellness e.g. via early intervention and social inclusion, rather than mental illness.
- Increase drug and alcohol capacity building in mental health services

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

Increase the focus on dual diagnosis and dual diagnosis support / treatment options.

In Victoria, client health information is owned by the GP in many instances (although now there is an online health records system). In other states, the government owns that information and this should be universal.

Change the language around lived experience to recognise it as a qualification.

Consider development of mobile phone apps for people living with chronic mental illness and their families for supporting the management of chronic mental health conditions and for early intervention (particularly for youth). Current mental health apps are quite basic; with technology improving daily, consider a product with the capabilities of e.g. the eRecovery app which has a panic button, daily check in, positive affirmations, which can be accessed by clinicians.

CLIENT RESPONSES TO QUESTIONS

1. **How can the Victorian community reduce the stigma and discrimination associated with mental illness?**

Unable to answer (Client answer in question 6 relates to this question. Further immediate access to supports would help people to be less vulnerable out in the community.)

2. **What is already working well and what ideas do you have to better prevent mental illness and to support people to get earlier treatment and support?**

Unable to answer.

3. **What ideas do you have to prevent suicide?**

Client referred to self and stated how she prevents herself from committing suicide and that's think of her babies.

4. **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.**

Client recognised that in her life everything is bad (Chaos), there's patterns of negative behaviours which set you up to fail and make her look bad because she had no other way of reacting when she feels so helpless, and no one can help.

5. **What areas and ideas for change would you like the Royal Commission to prioritise?**

Easy and quick access to talk to someone who specialises and understands mental health and doesn't treat us badly which highlights and supports our babies taken from us. (Client was using in the past; her mental health is now the main reason for her children not being returned.)

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

Need more available emergency crisis intervention. (Currently you need to be suicidal to have the most basic intervention/support.) There is a need for people who are specialised in Mental Health to support the general population.

1. **How can the Victorian community reduce the stigma and discrimination associated with mental illness?**

   This needs to start in schools. Educating children about the importance of mental health, because a lot of mental illness is developed from a young age. If we start teaching children, from a young age about the importance of mental health it can then be discussed freely thought a person's life. At the moment, if it is not seen, it is not an issue.

   There are campaigns and adverts, but is this an excuse for not properly funding facilities? Training, education and campaigns are cheap. Facilities that will really treat people like myself are expensive. I would much rather be misunderstood and treated properly than the other way around. A brochure is not going to help me.

   Consumer consultants, "recovery champions", should be employed and valued by each community. Their job will be to instil hope, act as role models, talk with individuals and workers. Let the community know about mental health problems.

2. **What is already working well and what ideas do you have to better prevent mental illness and to support people to get earlier treatment and support?**

   Specific facilities for people suffering from mental health problems. Like Odyssey House Circuit Breaker. Therapeutic Communities, where the whole person is treated. It's a simple answer, more facilities like Circuit Breaker.

3. **What ideas do you have to prevent suicide?**

   Emergency departments need to take people seriously when thy present with suicidal ideation. Mental health workers are cynical. They don't know what to do. They fob you off. They don't help. Send you back from the where you are seeking health, to a place, a subculture of drugs or addiction, or mental illness who are the only people who will not reject you. But of course, things then get worse.

   It takes courage to ask for help. I don't think they realise that. But your courage and desperation are thrown back at you, which makes things worse. Help is not available. There are no facilities to go to.

4. 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.

There is nowhere. Nowhere specific for people like me with an eating disorder and a substance abuse disorder to go. There will be thousands of people like me. Eating disorders predispose one to substance abuse. Where do I go? Where does someone will the severity of mental health problems like me go? I go to the GP, I get a referral. Four weeks later I get an appointment. To speak with someone for one hour every two weeks. It's not enough.

5. What areas and ideas for change would you like the Royal Commission to prioritise?

- More facilities. Buildings. Staff. Real place to go, like Circuit Breaker that will treat you holistically.
- Consumer consultants in every community. People who have been through it. Recovery champions, from addiction and other mental health problems
- Training for mental health workers to emphasise the severity of the experience for the consumer

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

People are suffering terrible amounts of pain, and dying. People like me are not hopeless. I have the potential to live a rich and meaningful life. I need properly funded, physical facilities. Buildings, staff, recovery champions who work there. When I ask for help, it takes courage, because I know I'm likely to be humiliated again, but when I ask for help, what I want is help.

[redacted]