Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF JANET MEAGHER AM

I, Janet Meagher, say as follows:

1 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

2 I am an advocate for people with lived experience of mental illness to enjoy a “contributing life”. A “contributing life” is a life that is fulfilling, enriched by close connections to family, friends and our communities of choice.

What is your background and experience?

3 I am currently a member of the Independent Advisory Council of the National Disability Insurance Agency.

4 From 2012 to 2013 I was appointed to be a Mental Health Commissioner for the National Mental Health Commission. I have also been a member of numerous ministerial and advisory bodies in relation to mental health, suicide prevention and human rights, as well involved as a founder and member of state, national and international mental health movements.

5 Attached to this statement and marked ‘JM-1’ is a copy of my CV.

What is your lived experience of mental illness?

6 I grew up in Newcastle in a fairly impoverished family. After teachers’ college in Sydney, I became a teacher, and then became a nun several years later. After a time, I had a “nervous breakdown”, as it was euphemistically called at the time. Subsequently, I experienced a series of major acute episodes during which time I used most of the private psychiatric hospitals in Sydney. I was moved into the public hospital system when no one else in the private system could deal with my behaviours.

7 In or around the late 1960s, when I was in my twenties, it was clear that I had paranoid schizophrenia. I was deemed, under the Mental Health Act to be mentally incompetent and held in psychiatric care at the pleasure of her majesty and thereafter, was institutionalised. My total period of hospitalisation extended for nearly a decade. In the large psychiatric hospital, at this time, there was a significant level of abuse and human rights infractions towards vulnerable patients. Every imaginable type of abuse happened

to me: physical, sexual and emotional abuse. By way of example, if you had extra medication in your night medicines you knew it was your “turn”; if you understand what I mean? Those who complained soon discovered that it was pointless because it led to being placed into solitary confinement. In a single small room you were stripped of your clothes. It was pretty simple for those staff to “manage” anybody who tried to speak up. These abuses exacerbated my feelings of distrust and made me feel utterly devoid of hope.

8 There was nothing that could be done about it, no-one was there to help me, or anybody else. No-one could do anything to protect us. In retrospect, it’s clear that these abuses and humiliations were drivers for my motivation to one day see that these damaging unavoidable experiences would be eliminated. These were part of my formative years, my later rationale for becoming an advocate. In my future, I’d see to it that there would be plenty we could do, that people would be educated to understand that there are a plethora of protections and many people there to ensure institutionally based intimidation and abuse couldn’t ever be hidden or secretive in the future.

9 In the interests of offering a balanced view, I need to emphasise that alongside all of the aberrant and illegal behaviours of staff that I’ve outlined above, there were many other staff that worked hard, with integrity and were diligently committed to the interests of their patients. For some of them, they did this despite the ongoing and serious culture of bullying and intimidation. They struggled and persisted to maintain a humane culture within that hospital. Some of the relationships I developed with a number of supportive, kindly and helpful staff during this time, were pivotal during my years of rehabilitation and recovery. Over the years since then, I have met with, encountered and, with a few, made long lasting friendships with those who were supportive staff from that time in my life.

10 A significant part of my rehabilitation happened right at the end of my time in the institution. I went to TAFE and began a course in librarianship. Another patient applied for a job in my name and got me a job as a library officer in a Sydney TAFE library. I spent every day on the job sleeping on the floor of the locker-room. When it came time for my employment review I was told I wasn’t entitled to a salary increment. In my utter ignorance, I was incredulous! They went on and told me that I’d have to actually do the work to earn an increase of salary. All this time I was still a patient in the hospital. The psychiatrist decided that if I was to be able to actually “work” in my job, then I’d have to be taken off the very large doses of tranquillisers, they did so, without their worst fears about my behaviour being realised. From that point this was the first time that I was able to actually work in my employment. I also began to work as a cleaner in posh houses not far from the hospital.

11 I was officially discharged around 1979/1980 as part of an experimental rehabilitation program. I was placed in a small group accommodation place with other long-term patients.

12 I was left so angry at what had happened to me and the other patients in the hospital. This made me highly motivated to work out how to become independent of the system and to work out how to raise awareness about what happens to incredibly vulnerable people in the name of care and treatment. My psychiatrist said to me that if I thought about it, this gave me a purpose, and said "use your brain, your intelligence, rather than your emotions. Let your emotions fuel your learning and your understanding of the systems that allow this to happen". She said something like "I can't change it, but you can. Learn everything you can about the system, know all the controls. Then once you know, you'll know what's expected, and, when there's a breach, you'll have the tools to do something about it. To get a better deal for patients"

13 Subsequently, I read up on the Mental Health Act (NSW), which was being revised. I understood only about a tenth of it but, by going to meetings about the proposed changes, it became very clear to me that the implications of this type of knowledge were huge. Bit by bit I met people who were experienced in lobbying. I joined some of the organisations involved in lobbying for the changes. Not everything went well, some people and organizations rejected me because they didn't want to work with "mad" people; some carers told me that they didn't want to be reminded, by my presence of "what we put up with at home" from their mentally ill "loved ones". I joined the Mental Health Association of NSW (MHA), and, later, in 1986, the Schizophrenia Fellowship. MHA was most welcoming and mentored and supported me to undertake increasingly sophisticated roles and responsibilities. From that point onwards, I became a board member, secretary of the association, a state representative for the national body, and from there, a representative at an international level.

14 The knowledge that schizophrenia is part of who I am, is now integrated into my persona. I hold the somewhat radical view, where I no longer view it as a problem needing to be treated or eliminated but as a normal aspect of me that merely needs to be managed and monitored, and, on odd occasions, treated. My symptoms have been integrated into my life without substantive negative impact. The mindset that I now have is hard to practice and was difficult to learn but it makes for a much greater personal quality of life. This mindset has also allowed me to reach some of my remaining potential, to overcome my negative behaviours, and has shaped how I apply myself to the pursuits of my life.

15 I have become a person who now lives a full and rewarding life. I am now able to contribute at the highest levels of government and to state, national and international mental health movements with enthusiasm and vigour. In this work I have lobbied for

enhanced recognition and respect for those people across the world who live with mental health issues or emotional distress.

Partnership or Pretence

16 In 1993, the Human Rights and Equal Opportunity Commission released the report *Human Rights and Mental Illness*. It became apparent that it was an opportune time to find ways to make lasting and practical suggestions, which would improve and consolidate the role of the Australian mental health consumer. The Australian mental health consumer movement had not developed to its full potential, and there was an opportunity to learn from others' ideas and models, and implement valuable lessons from overseas groups, and from their successes, problems and experiences.

17 A friend of mine coerced me to apply for a Churchill Fellowship. She said something like "you can make a real difference for the rest of us, leave us behind, we'll follow." By 1994 I already felt that I was leaving people behind – the knowledge I had been gaining meant I was now beyond the helpless stage. I wanted to move other people who were living with mental health issues to the next stage where they could better understand their right to expect something worthwhile and better, which is they shouldn't expect to be harmed by their care and treatment.

18 My application for a Churchill Fellowship was successful. The Winston Churchill Trust funded my study tour through Great Britain, the USA and Canada where I investigated consumer self-advocacy and empowerment programs. The results of this investigation were published in 1996 as a book, *Partnership or Pretence: a handbook of empowerment and self-advocacy for consumers of psychiatric services and those who provide or plan those services*. The book had two revised editions and went on to be published in Japanese (2 different translations), Mandarin and Spanish.

19 My hope and goal was, and still is, that people who use mental health services will have no risk of being emotionally, physically or spiritually damaged by their "care", by treatments, or by insensitive policies, or inappropriate behaviours of personnel. They will experience respect and have real input into treatment decisions, and have a guaranteed quality of service.

20 My goal was also for those who have used services to have input regarding all aspects of service delivery, policy making, and any issues that affect their quality of life. People using services need to learn to work in partnership with mental health bureaucrats, professionals and service providers through an empowerment and self-advocacy process. *Partnership or Pretence* advocates for genuine partnership in all undertakings, and aims to equip people with the tools to make a genuine partnership a reality.

What is a "contributing life" and why is it important?

21 The National Mental Health Commission wanted a framework to integrate care and support into a person's whole life trajectory – in other words; the person is not just a mental illness walking around. As a Commissioner, I was intensively involved in the work involved in developing this concept. I had come across the notion of a "contributing life" at some point during my involvement with the disability sector. By way of background, I should make clear that I am quite against people being seen as a "patient" (i.e. as a passive recipient of service), because patienthood is only ever a small proportion of anyone's life. I want a person who uses mental health supports to be seen as someone with potential, who has something to offer the world, who just needs assistance at this point in time to enable them to move forward to achieve those hopes and dreams.

22 As a result of my suggested approach toward describing what attitude we needed to reflect in describing the purpose of mental health services, the Commission developed a "Contributing Life" framework. This framework sets out the type of life all of us wish to attain. What all humans want is a fulfilling life enriched by close connections to family, friends and our communities of choice. It has application generally but is particularly relevant in the context of supporting those who are experiencing issues with their mental health and emotional wellbeing. It enables a hopeful outlook, eliminates the negative "you'll be sick for the rest of your life" mentality. We need to treat people to enable a life worth living.

23 There are a number of parts to the Contributing Life framework:

(a) thriving, not just surviving;

(b) effective support, care and treatment;

(c) something meaningful to do, something to look forward to;

(d) connections to family, friends, culture and community;

(e) feeling safe, stable and secure; and

(f) preventing suicide.

24 I need to point out that a contributing life is not usually the sort of life that a person experiencing chronic mental health issues would ever hope to be able to live. This mindset can be changed by adopting attitudes based on research, and by consistently offering evidence-based supports that respectfully support the person's psychological trajectory through the psychosocial and clinical relationship. All interventions ought to be focussed on restoring the person's capacity and ability to nurture their hopes and dreams in order for them to attain to a contributing life for themselves.

25 All of us will be profoundly affected at some stage in our lives by mental ill health – either directly, in our family, or circles of friends, or at work. That is why we need to highlight the things that matter to all our lives: where we live, what we do, our friendships and community and what we need to help us live a full and contributing life. The comprehensive impacts of experiencing mental health issues must result in a much more effective and humane response from services. This is why the contributing life framework must be implemented as the strategic direction for mental health services into the future.

How difficult can it be for people with lived experience of mental health issues to have a contributing life?

26 The effort, control, guts and sheer willpower that it takes for a person with a mental health issue to participate fully in society is extraordinary. I do believe that it does take a lot more guts to be a person in recovery and it takes even more guts to keep yourself well enough to maintain your achievements. In time it does get easier but the drive, and encouragement to maintain the drive must always be there.

27 All of these efforts and strategising to develop aspects of skills and competencies are constantly working against the disease structures and psychological strictures. Attempting to live a contributing life is an incremental clawing back, a metaphorical battle to gain ground lost to the disorder and to succeed, to win against all the limitations.

28 To compare this journey to anyone else who does not live with a mental health issue, we must think of their challenges and vulnerabilities and then multiply that by a factor of at least ten. Then we will have a glimpse of just how difficult it is for someone who lives with mental health issues to live a contributing life. Every day in every way everything is a challenge, but, with appropriate assistance, it is never an insurmountable one.

29 Opportunities for recovery and rehabilitation can be severely impacted by the lived experiences of people with mental illness. These experiences can include mental health crises and admissions to acute psychiatric hospital wards, periods of hopelessness, disrespect, abuse, homelessness, time spent living in “half way homes” and physical, sexual, financial and emotional assault. These experiences can leave people confused, traumatised, alienated and anti-social.

30 Mental health issues alone are not responsible for these traumas. These traumas are external consequences that most commonly arise because the person was unlucky enough to have developed a severe mental illness.

31 It is these external consequences that we can address and eliminate from the process of treatment and support to enable future opportunities for people living with mental health issues to lead contributing lives.

Does negative stereotyping still exist? What are its impacts?

32 Many people who experience mental health issues are labelled impersonally as, “a patient”, “a client” or “the consumer” or have a diagnosis that represents only what is seen as their “sick” or “broken” parts. People see them not so much as a person, but more so as a diagnosis (e.g. “a depressive”, “a schizo”, “a crazy one” etc. etc.) and frequently as inherently dangerous and not to be trusted. This can lead to people being fearful or afraid when they come across people with mental health issues. I have experienced this fear first hand after people have become aware of my mental health status. Related to this, I was never able to get income insurance and when I travel I struggle to get travel insurance.

33 In addition, problems encountered along people’s life paths have typically been regarded as the result of their “weakness”, faulty bodies or malfunctioning brains, rather than as an outcome of trauma. In some instances, an aspect of this trauma can be due to the ways that they have been affected by a variety of bureaucratic and environmental factors including poor interactions with the mental health system or those working within it.

How can the mental health system assist people with personal experience of mental health issues to live contributing lives?

34 Many people with personal experience of mental health issues report negatively on their experience of mental health professionals and their failure to treat them with dignity and respect. In particular, people report that:

(a) they are largely understood by reference to their diagnosed mental illness;

(b) their personal and social issues are ignored;

(c) there is little empathy and understanding for their position;

(d) their potential for growth is ignored; and

(e) mental health professionals often fail to acknowledge their own feelings or personal mental health status.

35 Often people with personal experience of mental illness have been taught that others are the experts, that there is a professional who has “the answer”, knows what is best and that there are only limited, rigid versions of the way forward. Few people have been

helped to develop ways of finding meaning in their life experiences. That is, to live a contributing life.

36 The mental health system can only assist people to live contributing lives when the principles of involvement, genuine partnership and empowerment are central to its operation. These principles are necessary to ensure that the mental health system can:

(a) understand and recognise each individual’s strengths and vulnerabilities;

(b) provide an opportunity for these to be acknowledged and worked on; and

(c) ensure that people are not emotionally, physically or spiritually damaged by their mental health treatment, by insensitive policies or by inappropriate personnel.

Recommendations for reform

37 In my view, the following could be done better:

(a) The mental health system and mental health professionals need to listen to the people using the services. The system needs to “make real” the desire of those people to participate and work together in genuine partnerships for change. If we want an effective system, we need input of people’s need.

(b) The mental health system is currently too focused on the medical and compliance side of treatment. In my opinion, mental health practitioners are mainly interested in making sure that people are, for example, taking their tablets or adhering to their community treatment order. The system needs to be more interested in the human side, that is, the side of treatment that allows people to have a contributing life, and provides them with the support to achieve this.

(c) Mental health services need to show that they recognise how hard it can be to live a contributing life. For example, the effect of medication can make it really hard to sleep normal hours. Sometimes people make a massive effort to do something, for example to get to an appointment or to work on time, and no one understands or recognises when efforts are being made. That effort often goes unrecognised and the person loses motivation. Eventually, most people are left without anyone caring about them, their struggles, their small achievements and they frequently give up. What is the point of even trying if no one cares? This re-enforces pervading feelings of hopelessness. I feel that the system can do more to ensure that people feel that there is someone who cares for them. People should not be punished because of illness symptoms, or the effects of medication, they should be treated with respect and a loving concern, and be expected to recover.

(d) The comprehensive impacts of experiencing mental health issues must result in a much more effective and humane response from services. This is why the contributing life framework must be implemented as the strategic direction for mental health services into the future.

(e) The principle behind the notion of contributing life is that services and policy should be geared at helping someone gain/regain purpose in life. A new service framework and strategy must overtly move beyond focusing on beds, acute care and clinical services and move on to include non-government/community services across all sectors, including peer and family workers. People with mental health problems want the same things as everyone else. Even the most disadvantaged should be able to lead a contributing life. There is more to people's lives than the services they use; they are, of course important, but we must look not just at the number of services, but also their range, availability, accessibility and quality. We must agree and report on a number of meaningful indicators and ambitious, but achievable targets. These need to concentrate and link up effort in all the areas that help people to live contributing lives: having a home, having something meaningful to do, improving opportunities, attaining good personal health, having healthy relationships and having adequate mental health and social supports.

(f) Consumers should inform the design of hospitals and other treatment settings. People should be asked what they need when they enter a service. For example, a quiet space free from stimulation, where I can regain control of my thinking and processes. We need an approach that listens to people with mental health issues and prioritises a "'whole of life" and wellbeing perspective.

(g) The mental health system needs to realise that people utilising the system need support outside of hospital and treatment settings. We must have access to rehabilitation and recovery-based services. I was fortunate to have access to a rehabilitation program where social workers checked up that I was going to work, was managing my life and responsibilities in regard to accommodation and was coping in my training and job. They matched me up with activities to contribute to the community. This allowed me genuine recovery and rehabilitation. This is something for which I remain thankful and still, many years later, utilise those strategies every day.

sign here ► J Meagher

print name Janet Meagher AM

date 1/7/2019

Royal Commission into
Victoria's Mental Health System

ATTACHMENT JM-1

This is the attachment marked ‘JM-1’ referred to in the witness statement of Janet Meagher AM dated 1 July 2019.

JANET MEAGHER AM

Curriculum Vitae

Version 5.   June 2019

Personal Details

Name	JANET MEAGHER AM
Date of Birth	04/12/1946
Citizenship	Australian

Relevant Background

Generic

Mental Health Activist since 1979, Developed major mental health issues 1969. Lived with schizophrenia since that time.

Current status: Retired

Activist/Advisor Roles

Advocacy for people who live with mental health issues, lobbying for mental health and psychosocial disability causes, promoting participation and genuine partnership for people who live with mental health issues, ensuring equity and rights, promoting peer roles, educator and trainer, speaker and representative.

Ministerial Appointments

National Mental Health Commission – Commissioner. 2012- 2013.

National Disability Insurance Agency, Independent Advisory Council Member. 2013-present.

Mental Health Expert Working Group. 2011-2013.

Australian Suicide Prevention Advisory Council. 2008-2010, 2012- 2014, 2016.

National People with Disability and Carer Advisory Council 2008-11, 2012-2014.

Earlier

Human Rights and Equal Opportunity Commission: Abuse in Institutional Care Working Group. 1997?

Human Rights and Mental Illness Inquiry: Reference Group. 1990-1992.

Dept Health: Advisor/ Appointed member…..

- Consumer Outcomes Taskforce: co-opted to team developing “Mental Health Statement of Rights and Responsibilities” for Aust. Health Ministers Advisory Council [AHMAC]. 1990-1991
- Development of Mental Health Standards: Working Group. 1995.
- Psychiatric Evaluation: Working Group. 1995.
- Review of the Commonwealth Disability Strategy: Reference Group.1997.
- Community Development Project: Working Group developed ‘The Kit’. 1997-1999.
- Attitudes of Health Professionals Project: Advisory Working Group. 1998-1999.
- Media Awareness Project, later Media and Mental Health Advisory Committee: 2000-2009.

Honours, Awards

Australian Mental Health Prize, 2017

Mayoral Minute, Rockdale City Council. 2006

Honorary Life Membership. NSW Association for Mental Health. 2005.

Community Award, Hughes Electorate. 2005

Gold Award - “Exceptional Contribution to Mental Health Services in Australia & New Zealand”- 2000 -TheMHS Mental Health Service Achievement Awards.

Member of the Order of Australia-1996.

“For service as an advocate for people with mental illness and psychiatric disability.”

Churchill Fellow 1994,

Investigated “Consumer empowerment and self advocacy” in UK, USA and Canada.

Humanitarian award of achievement and excellence

for the advancement and improvement of Mental Health Services- 1992-1998 NSW Consumer Advisory Group.

“**Patron**” for Sane Australia and Independent Community Living Inc.[ICLA]

Founder Foundation Committee member “lived experience” orgs.

National Mental Health Consumer Carer Forum [NMHCCF] 2002+.

Australian Mental Health Consumer Network [AMHCN] 1996-2009.

NSW Consumer Advisory Group- Mental Health Inc. [NSW CAG, now known as BEING] 1992+.

Consumer Consultant Resource Group, Rozelle NSW.1992. [This Group supported and employed first professional consumer consultants/ peer workers in Australia]

Schizophrenia Fellowship- Sydney South.1986.

Organizational Involvements

National Mental Health Consumer and Carer Forum [NMHCCF]. Inaugural Consumer Co-Chair, 2002-6, Member 2002-2017.

National MH Commission -Consumer Carer Leadership Group, Patron, Trainer and Mentor 2013-2014
Flourish Australia [Formerly PRA], Board member 1998-2000. General Manager Inclusion, 2001-2013.

Consumers Health Forum- consumer representative. 2002-2017

World Federation for Mental Health [WFMH]. Board Member at Large, Secretary.1996-2005.

Australian Federation of Disability Organizations [AFDO], Board Member (Psychosocial Disability) 2004-2008.

NSW Institute of Psychiatry, Advisory Committee for Development of Consumer Advocacy Course and Recovery Curriculum. 2001-2010, 2011-2013.

Industry Skills Council, Expert Industry Working Group: Development of Mental Health Peer Work Qualification. 2010-2012.

Mental Health Co-ordinating Council of NSW: Working Group on Physical Health and Mental Illness. 2011-2014.

Consumer Activity Network [CAN], Co-produced and delivered, with D. Casey, course work on "Introduction to Peer Work" training package. 2009-2011.

ACROD (now NDS) Board Member (representing Australian Psychiatric Disability Coalition), 1991-2000.

People with Disabilities [PWD NSW], Committee Member 'Disability Complaints Service', 1995-1997.

NSW Consumer Advisory Group [NSW CAG] Executive Director. 1999-2001.

Writing / Communication

Editorial Committees:

Journals- Advances in Mental Health, Mental Health in Australia, Transcultural Mental Health. *Magazines*- Panorama

Peer Work in Australia. Published September 2018.

Authorship:

"*Partnership or Pretence"* 2003, 2005 English editions,

2005 Mandarin, 2005 & 2016 Japanese editions, 2006 Spanish.

Scope, role and contribution of peer work: Section 1 of Peer Work in Australia Co-authored with Dr Gerry Naughtin.

Academic papers:

'Mental Health and Human Rights' Oxford Uni. Press, 2011. Chapter, *"Consumer contribution to World Associations and the UN."*
*Service User and Carer Stakeholder Perspectives on the Public Health Aspects of Diagnosis and Classification of Mental Illnesses.*Diana Rose, Graham Thornicroft, Nobuko Kobayashi,
Oliver Lewis, Janet Meagher, and Inger Nilsson. Geneva 2007.

Articles (various) for newsletters, magazines and websites.

Training and education courses for bureaucrats, departments, community sector and consumers/carers written and delivered. In person, online and in podcasts.

Curriculum development and advice. E.g. Industry Skills Council Devt. -Cert IV Mental Health Peer Work (2010-2012), MHCC (RTO) various advisory roles 2008-2012 NSW Institute Psychiatry – Advisory Committee for Consumer Advocacy course 2001-2010, Recovery modules etc. Consumer Activity Network- Collaboration with D.Casey to develop course-"*Introduction to Peer Work*." 2009-2011.

Organizational documentation: - peer workforce initiatives, policies and procedures, staff handbooks, supported employee handbook, QA audits. "*Embracing inclusion", "Recovery Action Plan*,"

NMHCCF Advocacy briefs co-authored with peers include, "*Consumer and Carer participation", "Person centered approaches to care and support", "Physical health impacts of mental illness and its treatments", "Psychosocial disability".*

NMHCCF Position Paper, researched and co-authored with peers "*Unraveling Psychosocial Disability" 2011.*

Co authored with Dr Gerry Naughtin "*Implementing the NDIS for people with disabilities related to mental health issues" 2014*, "*Improving access for people in psychiatric hostels, supported residential services and boarding houses" 2016, "Guidance on the application and promotion of peer work in the NDIS" 2017, "Peer Workers in the NDIS" 2017* etc.etc

Other Related Activities

Active in Disability Sector since International Year of Disabled Persons (1979),
Mentor, advisor and supporter in formal and informal consumer settings,
from World Federation for Mental Health to national and state groups and individuals.

Education

1965-1966	Australian Catholic University- Teaching -Undergraduate Diploma
1980	TAFE NSW- Library Practice- Associate Diploma

Employment History

August 2001 to 2015

General Manager- Inclusion

RichmondPRA (Now Flourish).

Senior management role incorporating:

- *Affirmative action program for people living with mental health issues as staff across organization*
- *Policy and procedure development*
- *Quality Assurance Audits and standards conformance*
- *Incidents and Complaints Practice management*
- *Staff development and training*
- *Projects that facilitate participation of people who live with mental health issues at all levels of organization*
- *Peer Worker policy and workforce development*
- *Publications*
- *Sector engagement*

December 1999- July 2001

Executive Director

NSW Consumer Advisory Group Mental Health Inc. (Now BEING)

Management role incorporating

- *Developing documentation for organization*
- *Setting up policies and procedures*
- *Training and supporting Board of Management, Chairperson and members*
- *Establishing Peak Body and its state office incl. setup computer network and office staffing*
- *Setting up management structure, resource library and filing system*
- *Provision of and training for representatives, being people living with mental health issues and family members.*
- *Organizing and promoting fora, seminars and conferences*
- *Lecturing in undergraduate specialist MH university courses*
- *Liaison, advice and reporting to NSW Dept. Health*
- *Writing Newsletters and promoting issues relevant to people living with mental health issues and their carers*

1990- 1999

Coordinator- Housebound Library Services

Rockdale City Council

Librarianship role requiring setting up and establishment of innovative dynamic library outreach services for aged and disabled citizens of the Council area.

1980 -December 1989

Library Officer

Sydney TAFE College Library, Bankstown and Gymea TAFE College Libraries

Library Assistant- Part Time

St John Bosco School Library, Engadine and

Teacher/ Lecturer- Part Time
TAFE School of Business and Administrative Studies, Gymea

Lecturer
Community College
Community Adult Education
Kringen (Specialist Studies for Adults with Intellectual Disabilities),

Personal matters
1969-1980

Schizophrenia: from 1969 to the present.

After onset of schizophrenia I had various hospital stays leading to my institutionalization at a large state hospital and eventually placement in the 'back ward' as a person unlikely to get well ever again.

For me it was an horrific experience, but gradually I began to see it as having some value. It was the 'University of Experience' and this, my harsh consumer education, has informed my learning and advocacy about

- *Rights, trauma, abuse*
- *The need for redress for inadequate policy and rights infringement*
- *Strengthening legislative and bureaucratic protections*
- *Development of an empathetic and responsive service ethos*
- *Effective treatments are more diverse than mere ECT and pharmaceuticals*
- *Respect for the consumer and their experience*
- *Consumer participation at all levels of mental health policy and service provision*
- *No-one should ever be damaged by their MH care and treatment*
- *Everyone in MH Care deserves to have hope for recovery and access to rehabilitation and recovery opportunities*
- *There is always hope for every one of us*
- *We help others by engendering a spirit of "*you can do it, we can help*"*

"This is not the end, it is not the beginning of the end,
but it is perhaps, the end of the beginning" Winston Churchill