Submission to Royal Commission into Mental Health – Victoria.

1. **Introduction**

1.1 Personal

I am writing this as a private citizen. I identify as a consumer, a carer, a (now-retired) peer support worker with the [redacted] Mental [redacted] Awareness [redacted] ([redacted] and the volunteer co-facilitator of the [redacted] Connection – a peer support and advocacy group which has been meeting in [redacted] since May 2004. I am also a former [redacted] and [redacted] [redacted] teacher with 35 years' experience in Victorian schools.

1.2 My submission

Victoria's clinical, public Mental Health system is failing.

1.2.1 In 2017-18, 11% of Victorians received Medicare-subsidised mental hearh services.[1] In 2012-13 this figure was 8.6%. (86.1 per 1000 population). The intervenng years saw annual rises of 0.7%, 0.5%, 0.7%, 0.2% and 3% respectively. In each year, Victoria's percentage for this category was higher than any other State or Territory.[2]

1.2.2 Compulsory treatment is used more frequently in Victoria than in any other Australian jurisdiction. "Nationwide, people who were admitted to specialised psychiatric care for a mental health crisis were given an involuntary status under law in 2016-17 at an average rate of 45.4 per cent, according to the AIHW. In Victoria the rate of compulsion in 2015-16 was reported to be 52 per cent of hospitalisations overall. "[3] Other restrictive interventions are also frequesntly used. "Nationwide, people who were admitted to specialised psychiatric care for a mental health crisis were given an involuntary status under law in 2016-17 at an average rate of 45.4 per cent, according to the AIHW. In Victoria the rate of compulsion in 2015-16 was reported to be 52 per cent of hospitalisations overall. "[4] And, "In 2015-17, the AIHW reported that Victoria had the highest national rates of physical restraint (although data was not publicly available for Queensland). Under prevailing definitions used by the AIHW, Victoria's rate was more than double the national average.
"Victorian public sector acute hospitals also reported the highest average duration that a person was secluded. The average time a person in Victoria spent in seclusion in these settings in 2016-17 was reportedly 10 hours — again, more than double the national average reported by the AIHW."[5]

1.2.3 Nationwide, $375 per person was spent on mental health-related services in 2016-17[6], compared with $275 per person in 2006-07.[7] Despite this per cpita increase of 36%, the mental health and wellbeing of Australians is not seen to be improving.

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1 **Australian Institute of Health and Welfare, May 3, 2019** https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/medicare-services
2 **Australian Institute of Health and Welfare** Achived reports and data
3 **Why are the Rates of Restrictive Pracices in Victoria's Mental Health Services so High?** *Pursuit* www.pursuit.unimelb.edu.au
4 **Ibid**
5 **Ibid**
6 **Op cit** Australian Institute of Health and Welfare, May 3, 2019
7 **Latest mental health productivity data reveals scale of reform ahead** Dr Sebastian Rosenberg, Sydney Morning Herald, February 19, 2019

1.2.4 In Victoria, there are 29 approved mental health services, catering for all Victorians. 21 of these are expressly designated for adult patients (22 if Forensicare is included). These services are based at hospital centres, usually the main hospital in regional areas (eg [redacted] Hospital for [redacted] Region) and a specified hopital in metropolitam areas (eg [redacted] in Inner East Urban Area).
All of these services are based around a biomedical model – that mental illness has a physical cause resulting in chemical imbalances in the brain, and that these imbalances can be corrected by psychotropic medications to at best minimise the distressing symptoms of mental illness.
All medications are prescribed by doctors (usually psychiatrists under the direction of the Authorised Psychiatrist) on the basis of an interview or series of interviews of the patient by the examining doctor.
There are no physical tests to determine the presence of a mental illness.

1.2.5 The average life expectancy of a 'consumer'[8] is estimated to be 10 to 25 years less than the national average[9]. The gap between consumers and the population continues to grow.
While some of this growth can be attributed to suicide, psychotropic medications are also well documented in contributing to obesity, cardiovascular disease and early onset dementia.

2. **Changing Direction**

2.1 In 2014, Victoria came under a new Mental Health Act. That Act was promoted as giving involuntary consumers more participation in, and control over, their treatment by MHSs. This was formalisd in the Act's core principles

2.2 The mental health principles[10]

(1) The following are the mental health principles—
(a) persons receiving mental health services should be provided **assessment and treatment in the least restrictive way possible with voluntary assessment and treatment preferred**;
(b) persons receiving mental health services should be provided those services with the **aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life**;
(c) persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected;
(d) persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk;
(e) persons receiving mental health services should have their rights, dignity and autonomy respected and promoted;
(f) persons receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to;
(g) persons receiving mental health services should have their individual needs (whether as to culture, language, communication, age, disability, religion, gender, sexuality or other matters) recognised and responded to;

(h) Aboriginal persons receiving mental health services should have their distinct culture and identity recognised and responded to;

8 I will use 'consumer' to describe any person who is receiving mental health services in a public setting. While this is a contested term, it is the most comonly used and no consensus has been reached on an alternative.
9 **Sane Australia**
10 **Mental Health Act 2014** Section 11 Pp21-22 Emphasis added

(i) children and young persons receiving mental health services should have their best interests recognised and promoted as a primary consideration, including receiving services separately from adults, whenever this is possible;
(j) children, young persons and other dependents of persons receiving mental health services should have their needs, wellbeing and safety recognised and protected;
(k) carers (including children) for persons receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible;
(l) carers (including children) for persons receiving mental health services should have their role recognised, respected and supported.

2.3 Has the Mental Health Act 2014 made a substantial change to consumers' participation in, and control over, their treatment by MHSs?

The Annual Mental Health Report 2017-18 indicates that rates of mental health patients in the community remain quite stable from year to year, although the Victorian population has risen

Whole population

	2015–16	2016–17	2017–18
Total estimated residential population in Victoria (based on mental health area) ('000)*	6,049	6,158	6,266

People accessing mental health services†††

	2015–16	2016–17	2017–18
Mental health-related emergency department presentations**	83,024	87,197	92,610
Emergency department presentations that were mental health-related** (%)	5.04%	5.14%	5.27%

People accessing clinical mental health services†††

Consumers		2015–16	2016–17	2017–18
Consumers accessing clinical mental health services† ‡		67,559	66,487	72,859
Proportion of population receiving clinical care* (%)		1.12 %	1.08%	1.16%
Consumer location		2015–16	2016–17	2017–18
Consumer residential location (%)	Metro	62.7%	64.4%	64.2%
	Rural	34.8%	32.6%	32.9%
	Unknown/other	2.5%	2.9%	2.9%

64 VICTORIA'S MENTAL HEALTH SERVICES ANNUAL REPORT 2017–18

considerably..

Around 1.1% of the population accesses clinical mental health services each year.11 This has remained consistent over the 3 year period. Around $^{2}/_{3}$ of these are metropolitan residents. While around 36% of these citizens are 'new consumers accessing services (no access in the previous 5 years)', an alarming 14% have accessed the service for each of the previous 5 years. This represents more than 10,000 people.

It seems very high, but the same report indicates that 26,098 of these consumers are hospitalised in acute beds. 28% of all people who attend mental health services are subsequently hospitalised, which is more restrictive than I would have expected.

11 **Victoria's Mental Health Services Annual Report 2017-18** p64

According to the Mental Health Tribunal Annual Report 2017-2018, 13564 hearings were listed, which resulted in 7520 decisions being made. Of these, Compulsory Treatment Orders were made in 6127 hearings – a rate of 81%.12

Key statistics at a glance *^

	2017-18 Number	2016-17 Number	2015-16 Number
Hearings listed **	13,564	12,759	12,160
Hearings conducted	8,279	7,816	7,469
Decisions made	7,520	7,197	6,878
Adjourned	759	619	591
Treatment Orders made	6,127	5,925	5,603
TO / TTOs revoked	340	371	358
ECT Orders made	682	590	624
ECT applications refused	80	101	86
NMI hearings conducted	8	6	2
Statements of reasons requested	233	225	243
Applications to VCAT	39	33	20

Attendance at hearings

	2017-18 Number	2016-17 Number	2015-16 Number
Patients	4,751	4,709	3,992
Family members	1,464	1,313	1,088
Carers	549	422	363
Nominated persons	222	180	308
Legal representatives	1,213	1,198	1,049
Interpreters	443	290	236

* *The figures in Parts 2.1 to 2.8 represent determinations at substantive hearings and exclude hearings that were adjourned or made without a determination.*

** *There are more hearings listed than conducted because hearings may not proceed due to changes in a patient's circumstances. For example, a hearing may be listed for a patient but prior to the hearing date the patient's Order is revoked, meaning the person is no longer a compulsory patient and they no longer require a hearing.*

^ *Figures for 2015-16 and 2016-17 may vary from figures published in previous Annual Reports due to improved reporting methodology.*

While the exact figures are not extractable, it appears that getting towards 50% of all hospitalisations are involuntary. This is surely unaccepable.

3. **Argument and Recommendation**

3.1 Victorians need an alternative to the current Mental Health Services.

In 2017-18, the Victorian Government spent $1.38billion on clinical mental health services. As the figures above demonstrate, this was for no perceptible improvement in the mental health of Victorians.

All Victorian mental health services employ the biomedical model of mental health. Simply put, this model claims that all mental illnesses are the result of chemical imbalances, or synaptic deficiencies, that can be controlled by medications that restore the balance, or overcome synaptic problems.

12 **Mental Health Tribunal Annual Report 2017-18** p17

It is essentially diagnosis and medication-focussed.

There is no physical test to detect any mental illness, despite the billions of dollars spent over many years by pharmaceutical companies.

The drugs employed by psychiatry are harmful to patients, as is evidenced by the lower life expectancy of consumers.

There are other models of mental ill-health, and mental health practice, which are much more conumer-focussed, community-focussed and collaborative. They do not use coercive treatments.

Three of these with which I have some (lay) familiarity, are:

The Open Dialogue model;

The Trieste model;

The Soteria model.

One of these, or another non-coercive model, should be trialled somewhere in Victoria, with appropriately trained staff and peer workers who believe in the model to operate it.

[redacted]

Your contribution

Should you wish to make a formal submission, please consider the questions below, noting that you do not have to respond to all of the questions, instead you may choose to respond to only some of them.

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

- Stop talking about 'mental illness' and talk instead about mental health, that it fluctuates in all of us, and from time to time some of us will benefit from talking to professionals, and even receiving treatment of some kind.

- Talk more about emotional distress, and how people cope with it in various ways. Using substances (medications as well as alcohol, tobacco and street drugs) has been a constant feature of human reaction to emotional distress for as long as archeologists have found evidence of human societies. We need to treat 'substance abuse' more rationally – we're certainly never going to eliminate it.

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?

- More sympathetic media coverage of celebrities (sportspeople, artists, celebrities etc) is helping remove stigma from anxiety and despression – psychosis not so much. Language is important and schizophrenia is both misunderstood and wrongly attributed. Psychiatry needs a discussion around this, as well as the broader community.

- Peer Support groups provide companionship, reduce social isolation, encourage community participation and offer people diagnosed with mental illness hope and friendship. They should be encouraged and helped to survive with accountable, but not restrictive, funding.

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

- Some of the causes of suicide as a society-wide phenomenon are well enough known. Poverty, domestic violence, despair over one's prospects, loss of hope that life will get better. While individual reasons are sometimes harder to determine, we can do more to eliminate poverty and domestic violence.

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.

- Remove coercive treatment from MHSs. Fear of being treated against their will is a continuallly expressed concern of consumers who have experienced coercive treatment, and is a major reason why they fail to seek help when their mental health is deteriorating.

- 8 members of [redacted] Connection discussed this submisssion. 6 of the 8 have received treatment from MHSs. None of the 6 have ever been asked about the many traumas that contributed (they believe) to their 'mental illness'. All have been told that their condition was caused by a chemical imbalance. Where is the Trauma Informed Care? Where is the acknowledgment that life circumstances impact upon people's mental and emotional stability? One of the 2 untreated by MHSs has had their trauma discussed, and non-medication therapies suggested. All 8 have received multiple medications.

- Living in poverty – Homelessness, DSP & Newstart levels, Introduce Universal Benefit Income

- Family violence – More funding for shelters, CASAs

- Support for volunteer Peer Support and Advocacy groups

- Statutory Requirement for all MH services to have supported consumer representation on committees and boards.

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

- Poverty and lack of employment opportunities.

- Lack of decent public transport options (particularly in outer suburban and regional centres)

- Lack of mental health community supports – NDIS benefits participants only.

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

7. What can be done to attract, retain and better support the mental health workforce, including peer support workers?
● Mandatory quotas for peer support workers in all government-funded MHSs.
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?
● Peer Support group funding
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?
● Compulsory ECT should be made more difficult for services to administer. The Mental Health Tribunal should be more rigorous about approvals/disapprovals ● Community mental health support through peer support funding for self-help groups. ● State-funded community MH support. ● Involuntary ECT treatments should be much harder for services to obtain. See judgment in Victoria's court which criticised the Mental Health Tribunal for its approval processes.

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

- Trauma Informed Care mandated in all MHSs. Penalties for services failing to provide adequatr education and training for existing staff.
- Remove coercive treatments.

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

This submission was developed co-operatively by 8 members of [redacted] Connection, a Peer Support and Advocacy group that has met weekly since May 2004 in [redacted]

All members are volunteers, and no member has ever been paid for work carried out on the group's behalf.

6 of the members involved are male, 2 female.

[redacted]

[redacted]

[redacted] Connection

Privacy acknowledgement	I understand that the Royal Commission works with the assistance of its advisers and service providers. I agree that personal information about me and provided by me will be handled as described on the Privacy Page. **X Yes** ☐ No