

Submission to the Royal Commission into Victoria's Mental Health System



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Introduction

This is a long submission, but it's been a long journey for me. Writing this has been hard. I procrastinated for great lengths of time, trying to avoid the pain that comes with revisiting these memories. However, I was determined to get it done, in case my story helps lead the way to a better mental health system. The current one is failing. We've lost so many people.

10 years ago, I was on a downward spiral; self-medicating with alcohol, getting arrested frequently and drinking to the point I required hospitalisation. These are the things people around me saw. Behind closed doors, I was self-harming, vomiting up everything I ate, drinking poison and regularly overdosing just to see if I would live through to the next day. While nobody knew everything I was doing, everybody knew I was in trouble. However, we aren't supposed to talk about mental health, so we didn't, and it only got worse from here.

On the 28th of January 2010, I was rushed to the emergency department. I had taken a significant overdose in an attempt to take my own life and ended up in a coma in the intensive care unit. This was the first of 3, very significant attempts to commit suicide; they got more serious from here.

It has been 10 years of incredibly hard work. I went from being extremely unwell, self-harming regularly, frequent suicide attempts, not attending work or university, binge drinking, not having anywhere to live and having a love affair with heroin - to having graduated with first class honours, getting a job as a practitioner in the mental health field, owning my own house, being clean from illicit drugs for almost 7 years, very rarely drinking alcohol, not self-harming for almost 2 years and not having attempted suicide for 8 years.

While I have worked unbelievably hard, every day for the past 10 years to get to where I am; we have not expected the same from the mental health system. Imagine the progress that could have been made over the last decade if we had learned to treat people experiencing mental ill-health with respect, learned to promote their dignity and human rights, empower them to take control of their lives and importantly, being open to learning from their experiences.

I hope we create some tangible systemic change from this Royal Commission. Those experiencing mental ill-health have been treated as second class citizens for too long. But we are not second class, we are living, breathing, human beings, capable of greatness. But only if we have systems that support this. The time for change is now.

We can and must create societies that include those experiencing mental ill-health, for we are your sisters, your mothers, your daughters, teachers, doctors and lawyers. We are us, and we are you, because the truth is, anybody can experience mental ill-health.

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

Normalising Mental Health

There were a million signs I was unwell, but we're not supposed to talk about mental health, so we didn't. I began self-harming when I was 12, started drinking and acting out at school at 14, failed school after not attending any classes at 15, binge drinking and blacking out at 16, isolating myself at 17, withdrawing from university at 18 and drinking every day by 19 while vomiting up everything I ate. In the meantime, I was high for months on end, the life of the party – then suddenly, things would change, and I'd isolate myself, and struggle to get out of bed for months on end – and then back to being the life of the party again.

When it's all written down, it seems obvious that something was wrong, I knew it, everyone around me probably knew I wasn't okay. We weren't encouraged to talk about these things though, so this pattern continued. Nobody wanted to speak about mental health, because it was 'something to be ashamed of'. I needed help, but I was too ashamed to ask, and people were ashamed for me, so they didn't bring it up.

I continued this incredibly destructive cycle, spending crazy amounts of money, doing things that I am ashamed of, losing all my friends. It wasn't until I was arrested, and the police officer spoke to me and my mum about the need to see a mental health professional. I wasn't ready to act on it at the time, but the thought was put in my head, and a few months later, I sought help.

It was the, 'I think you could use some help', that did it for me. Had that police officer, kept his thoughts to himself, I'm not sure what would've happened to me. I'm not sure how much longer I would have taken to seek help, I'm not sure I would've made it out alive.

I spoke to my sister recently and she talked about how when she looks back now, she realises 'how oblivious' she was (she was only 12 when I first attempted suicide so it was definitely not up to her to challenge my mental state). I've had friends from back then, contact me and apologise for not doing something for me, who was obviously struggling. I tell them all the same thing, we just didn't know what we know now, and maybe if we had of known, things could have been different.

At school, I learnt about the importance of a good diet, to prevent obesity, heart disease and stroke. I learned the signs for several health conditions. I did not learn about mental health. We need to be teaching this in schools. The younger we start talking about this stuff, the more normal it becomes. By teaching our children about mental health conditions, we can teach the next generation that it's okay to struggle sometimes and it's okay to ask for help. We can teach the next generation how to look for signs in themselves and others. We can make a true commitment to early intervention and we can destroy the stigma surrounding mental ill-health.

Stigma and Practitioner Attitudes

When I was about 20, I received an extra diagnosis. My treatment changed dramatically after that. Little did I know, I had just been labelled with a greatly stigmatised diagnosis. The professionals around me did not treat me with empathy, they treated me with contempt.

Not long after receiving this diagnosis my case manager told me that '[I am] impossible to help and [I'm] going to rot away in [my] own mess until [I] die'. In his case notes from that day he described me as uncooperative, hostile and passive aggressive. We appear to have very different perceptions of what happened that day. But he is the practitioner, the one with power. The story he told, was the only one that mattered. My experiences meant nothing.

I got taken to emergency one day to get sutures one day and the doctor told me, he wasn't, 'going to waste [his] time, because [I] was just going to do it again'. Another day I was taken to emergency to get sutures and the triage nurse told my psychiatric nurse, 'it's just superficial, she can wait'. I was covered in blood and losing consciousness when my psychiatric nurse got up again and argued with the triage nurse, telling her I needed help immediately. When I was taken in, the doctor said that I had hit an artery. I'm not sure what would have happened to me, had my psychiatric nurse not have been there to advocate for me.

Once, I took some bad GHB. I was lying on the floor, vomiting up blood. Too afraid to go to emergency because of how bad they treat people like me. I decided that if I died, that's how it was supposed to be. Yes, that's correct, to me, dying was a better option than attending an emergency department and re-traumatising myself with their hostile attitudes.

I have read through my case notes, and the contempt that some of these practitioners felt for me is very real and I felt that contempt throughout my treatment; while I was literally fighting for my life. It reinforced this self-stigma and I am still fighting it, over 6 years after I left clinical mental health services.

As a now qualified practitioner in the field, I can work with people just like me, and work with them through their recovery journey. But as a practitioner in the field, other practitioners speak much more openly about their prejudiced views and their belief in the stigma surrounding mental illness; in particular, highly stigmatised diagnoses, just like Borderline Personality Disorder. I find this really hard to deal with, and it's a new aspect of my recovery journey I now have to fight my way through.

Two weeks into my first job in the mental health field, I sat in a training session, facilitated by my organisation. One of my colleagues, openly said that 'people with borderline personality disorder are manipulative and attention seeking'. I was thrown. I looked around the room, hoping that someone other than me would challenge this. I looked toward my manager, nothing. It was up to me to challenge these stigmatised views, and so I did. Not a single other person offered their support.

I attended another training session, facilitated by an external organisation. The training emphasised the importance of breaking down the stigma around illicit drug use. I wholeheartedly agreed. This was definitely something I was behind. What I wasn't supportive of, was the facilitator of this training, making continuous, stigmatised jokes around Borderline Personality Disorder. You can't reduce the stigma around drug use, while perpetuating the stigma around mental health diagnoses.

I sat in a team meeting once, where a colleague spoke about how a consumer he works with, doesn't like being referred to as 'scattered'. He then proceeded to make jokes about how scattered the consumer was, my other colleagues laughing along with him. I called him on this, told him that it was disrespectful to his client and that I did not appreciate him mocking his client. After the meeting, I was pulled aside by management. My manager told me I had made 'everyone feel uncomfortable' by calling him out directly in a meeting. It did not matter that I felt uncomfortable listening to a colleague make fun of a consumer. It did not matter that a consumer was being made fun of. All that mattered to my manager was that people felt uncomfortable by me being direct and making it clear that mocking consumers is not acceptable. I could not even believe what I was hearing, I felt completely defeated.

These are not all my experiences, but it outlines a picture of what we're dealing with in the mental health field. It disgusts me that anybody with abhorrent views around mental illness is allowed to work in the field and it is something that needs to be addressed if we are going to make an honest commitment to help those battling an invisible illness.

The Language We Use

The language we use is incredibly important. It becomes the lens in which we describe our world view. Looking through my file, I can not only feel the contempt felt towards me by my practitioners, I can see why I was treated so awfully. I wasn't a human being to them. Just another number on their case load. Another burden on the health care system. Another 'waste of their time'. Here are a few choice words and phrases, extracted from my mental health file:

- Agitated and refused treatment
- Patient was guarded
- Maladaptive coping and personality traits
- Intubated as a result of behaviour
- Reluctant engagement
- Poor eye contact
- Subdued
- Provocative statements
- Antagonistic and irritable

- Themes of hopelessness
- Superficially cooperative
- Dismissive
- Emotionally unstable
- Highly aggressive
- Refused to examine any of her thoughts/actions
- Demanding perfect care
- Teary and distressed
- Long standing history of impulsivity
- Chronic high risk of suicide and misadventures
- Challenging to develop a rapport
- Restricted, irritable with rare smiles
- Maladaptive personality construct
- Shackled due to combative behaviour
- Inappropriate anger outbursts
- Refused to engage
- Belligerent and obstructive
- Manipulative content of information
- Oppositional and defensive
- Agitated and not obeying commands
- Combative needing restraints
- Challenging behaviours
- Difficult to engage
- Underlying irritability and antagonism
- Passive aggressive and manipulative
- Refused to engage
- Superficially cooperative
- Not forthcoming with the truth
- Her judgement and insight is poor
- Unwilling to engage
- Belligerent behaviours
- Underlying irritability
- Shackled in hospital gown
- Judgement impaired by impulsivity

- Selfish act
- Given reality feedback
- Intubated due to agitation
- Somewhat childlike with underlying antagonism
- Dismissive
- Impulsive
- Grudgingly accepting
- Remains guarded
- Uncooperative
- Hostile
- Passive aggressive
- Chronic high risk of suicide
- Complex client
- Poor judgement
- Demanded sutures
- Patient needed restraint
- Agitated and uncooperative
- Curt
- Disparaging at times
- Splitting
- Uncooperative
- Demanded sutures
- Unwilling to engage
- Little rapport established
- Underlying irritability
- Heightened sensitivity
- Impulsive and self-destructive
- Required restraint and shackles
- Hopeless and helpless themes
- Judgement questionable
- Guarded with avoidant- poor eye contact
- Childlike behaviour
- Affect factitious
- Immature defenses impairing judgement chronically

- Passively accepting of help without commitment to progress beyond sick role

It's a long list, and I haven't even read my entire file. I was a burden to them. New practitioners having read my file before meeting me, already having formed fairly strong opinions of me. What my file failed to mention was the strength it takes to endure living through the things that I have. It did not mention my hopes and dreams of becoming a practitioner, it did not mention how kind and compassionate I was.

My case notes were written from frustration. Practitioners who were angry because I did not appear to be getting better, and to be fair, I wasn't. Perhaps however, I wasn't getting better because I was only viewed through a deficit model. Practitioners were fairly quick to decide what was 'wrong with me'. They rarely wanted to explore my positive qualities, my strengths, my values and my plans for the future.

Looking through this deficit-focused lens has serious consequences. I once went to visit a consumer in a psychiatric unit. The registrar told me that if I needed to know how things worked around the unit, he'd be happy to answer any questions. I told him that I was fairly familiar, as I'd been hospitalised a number of times myself. He paused, for quite some time, and then offered support if I needed it. From the outside, it probably looked like he handled it well, and he did, for the most part. What is important here is the lengthy pause. He looked quite surprised that the practitioner standing beside him, had been unwell enough to be placed in hospital on numerous occasions.

The thing is, when we view people through a deficit model, we fail to see any real hope for their future. When we fail to see that hope, it is likely we will fail in assisting them towards this future. If we can't picture this individual living a long, happy, prosperous life, then we aren't going to be helping them work towards it. We will help them work towards the bleak and sheltered future we have pictured for them. We will never see them live to their full potential. We become more of a hindrance than a help.

The deficit model further perpetuates stigma. The deficit model needs to go in the bin.

Recommendations

- We need to normalise mental health. Going to see a professional for your mental health needs to be just as accepted as going to see a professional for a physical health condition. We do this by teaching mental health in schools, workplaces and targeted campaigns. We do this by having peer workers facilitating training, demonstrating that it is possible to have a mental health condition and lead a 'normal life'.

- Mental health needs to be taught in schools. The same as I learned about obesity and heart disease and stroke, I should have been taught about depression and anxiety and schizophrenia. By teaching young children about these conditions, we create normalcy, but we also create the next generation of individuals who will be able to spot the signs of people in trouble.
- We need better training in mental health. Especially regarding stigmatised diagnoses and especially for emergency services. This needs to be mandatory for all practitioners to complete, regardless of what professional field the practitioner comes from.
- We need more peer workers in the field. Peer workers are experts in recovery, however their pay scale indicates that they are not valued in the field. Better pay + more supports in the workplace = more peer workers (this will be touched on later).
- We need more supports in the workplace to reduce staff burnout. We need more education around what staff burnout looks like. Most practitioners think that becoming frustrated at their consumers is a given. When that frustration impacts your consumer's recovery, we have a problem. Staff need to be supported to reduce burnout and need to be able to recognise when they are experiencing burnout.
- We need better screening of practitioners. There are some people in the field that simply should not be there. There needs to be a clearer avenue for managers to follow if they have concerns regarding an individual's personal attitudes and the impact those attitudes are having on consumers. We work with some of the most vulnerable people in society, we must protect them from people causing harm.
- The deficit based model needs to go in the bin. We need to stop telling people what's wrong with them and start focusing on their strengths, values and their potential to lead the life they want to live. We need to challenge the language we use in order to start viewing individuals with a mental health condition as people, rather than as burdens.

2. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment?

Failing Services

My family situation was not ideal. My step father was an abusive drunk. I was terrified of him. I dealt with that trauma inwardly, I fell deeper and deeper into myself. My brother on the other hand, expressed his trauma outwardly.

My brother was continuously suspended from school. He was increasingly violent, and was both physically and sexually abusing me. The first memory I have of sexual abuse, I was about 4, the last I was 10. My brother would beat me with cricket bats and hockey sticks. He chased me with knives and tried to drown me. I was as terrified of him as I was of my step dad.

My mum spent a great deal of time, trying to get my brother help. She took him to psychologist after psychologist, doctor after doctor. None of which was helpful. My mum called Child Protection herself, telling them that she could not cope with my brother's behaviour, telling them that he was a danger to myself and my sisters. We were allocated a worker, who went on holidays, and we fell through the cracks.

My mum continued to talk to professionals about my brother to try and get him some help, to no avail. One day a practitioner told my mum to drop my brother off for a psychiatric evaluation and to not pick him up. That practitioner told my mum that abandoning my brother was the only way to get the attention of child protection.

It worked, my brother was put in foster care. He went from group home to group home and landed in the criminal justice system. The truth is, that's where a lot of people like my brother end up. As I always expressed my trauma inwardly, I ended up in the mental health system. Our two different ways of coping, leading us down two different paths, different, but equally bleak.

When I was about 25, I went through the documentation my mum had from Child Protection. My mum wasn't the first person to call them about us. Someone before her had made a report. The documentation states that someone from Child Protection tried to contact the family, but there was no answer. And that was it. We were left in our situation to rot.

I wish I could say that the system has changed and that things have gotten better. To this day, I have friends who cannot access services for their children who desperately need them. The behavioural issues displayed in childhood that will turn into full blown mental health conditions if these children can't access the services they require. And the services just aren't there.

Inaccessible Services

I first began utilising services as a youth, making me eligible for youth services. They claimed to have an early intervention approach (which I did not witness). Youth are at a crucial stage in development and require a different approach to mental health, which theoretically is why youth mental health services exist. These services however, have maximum timeframes for which you can utilise their services.

Youth is generally categorised between 16-24, however, if you begin using youth mental health at 16, you'll be dumped into the adult system at 18 as a result of the 2 year maximum use of services. At 18 even though your brain is not fully developed, even though you're still considered a youth theoretically, you'll be accessing adult mental health services who will be entirely inappropriate for your developing brain.

I was 19 when I first started using youth services, dumped into adult mental health at 21. I was not ready for this change (which is documented continuously through my mental health file). The service was not designed for somebody like me, and so I discharged myself, with no mental health support, other than my GP.

A few years later, my work situation was pretty bad and I wasn't coping with it at all. I contacted triage who told me that I wasn't unwell enough to meet the threshold for AMHS (which are fully subsidised). I was told to get a mental health plan, so that my psychology sessions could be partially subsidised. I wasn't attending work at that stage because it was too much for me. I was too sick to go to work, and without work, I was unable to pay for the treatment that could help me get back to work. I was lucky enough that my work paid for these sessions, but not everyone is in my situation.

Many people experiencing mental ill-health just don't have the resources to pay for treatment. Treatment for mental health should not only be for those who can afford it.

There are a few providers, here and there, that can be fully subsidised via a mental health plan. But even if you can find a provider, you can get a maximum of 10 sessions a year. This is not anywhere near enough. Personally, it would take about 7 of these sessions to even establish proper rapport and full trust with my practitioner, which leaves 2 therapeutic sessions, and 1 session wrapping up all the 'work' we did together. My trust issues are not unique, and many people are in a similar situation, whereby the time they have established a therapeutic working alliance, they are about to conclude with their practitioner.

AMHS are fully subsidised, but they are under a lot of pressure. There's a lot of demand on them for services, and case managers have large caseloads. Both as a consumer and in my work as a practitioner, I witnessed AMHS 'stabilise' individuals or help them achieve 'partial recovery' and then boot them out. They have to, their demand is too great and they are chronically under-resourced.

Community Mental Health (MHCSS), like AMHS, only worked with people who were considered to have severe mental health conditions. I found this silly. MHCSS has such a great potential to prevent people from getting to crisis. They had a unique way of working, utilising a recovery model, viewing people's strengths and values and helping them to live the life they wanted to live.

This model, utilised much earlier on in the picture, could save the government a substantial amount of money by preventing people from getting to the 'severe' category. However, MHCSS no longer exists, not even for those on the 'severe' end of the continuum. The model was scrapped, with the introduction of the National Disability Insurance Scheme (NDIS). A new model was announced to replace it (EIPSRs), but this model will only work with those already with an AMHS, leaving a substantial gap in the system. You must have a severe mental health condition to access AMHS, the new model of community mental health and the NDIS alike.

There are substantial costs involved in having only crisis-oriented services whereby we only fund services for those considered to have a mental health condition which severely impacts their functioning. We could save a bucket-load by funding early intervention, but this has clearly not been prioritised by the government to date.

Recommendations

- We need to start funding services earlier on. Some parents need help with their children's behaviour. If we are going to display a true commitment to early intervention, supports need to be available at the first indication that something is wrong.
- Mental health supports need to be fully subsidised, mental health treatment should not only be for those who can afford it.
- Mental health plans should fully subsidise mental health treatment for a period of time recommended by the treating practitioner. They should not be limited to 10 sessions per year.
- Community mental health needs to be reinstated properly, and the threshold for meeting the eligibility criteria should be lowered. If we want to claim a commitment to early intervention, we must see people earlier in their mental health journey.
- Youth mental health should not have short time frames for service provision. A young person should stay in youth mental health services until at least 24.
- As discussed in the above section, we need to reduce stigma. We need to make going to see a professional about your mental health as normal as it is to see a professional about your physical health. This will encourage people to access services earlier on.

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

Suicidal Thoughts

Every time I go get a new script for medication, or take a mental health day and require a certificate, I'm confronted with the same question, 'Are you having thoughts of suicide?'. The answer is yes, it's always yes. I've been in recovery for a long time, but I still have thoughts of ending my life. They're chronic, it doesn't mean I'm going to act on them.

What I then have to deal with, is general practitioners who are thrown by my answer. They ask me a million other questions to assess my risk, even though I've clearly articulated that I have chronic suicidality, but that I am not going to act on those thoughts.

We often work in a risk framework, where we are so far wrapped up in ticking all the boxes, that we forget that we are dealing with living, breathing, human beings. These questions asked of me are never asked with empathy, just a box ticking mentality, and they make me feel like crap, every single time. Instead of being commended on my ability to live with these thoughts and not act on them, my identity is reduced again to the 'full of deficits, mentally unwell patient'. It's awful.

This same risk framework had me hospitalised more times that I could count. I was continuously thrown in hospital, often involuntarily, to save me from myself.

Once, I had made a 'safety plan' with my case manager. That plan was to go stay with a friend overnight. My friend decided that she was going to go stay with people I didn't know. My anxiety was high and this was not something I could do, so I left.

I went to another friend's house, this friend was older, a mother. I would have been safe there. Instead of hearing me out, the police and an ambulance were sent to my friend's house and I was involuntarily admitted. Nothing I said was taken into consideration, I needed to be protected from myself, obviously.

Because of the seriousness of my suicide attempts, I was viewed through a high-risk lens. What that meant was, most of the conversations with practitioners revolved around my risk, and much of my 'therapeutic work' was me staying in inpatient units, where no real therapeutic work happens.

The thing with inpatient units is that they're these wonderful, clinical, safe places, hidden away from the world. A place where I didn't need to deal with my problems, a place where if I got upset, I was medicated out of my mind. Inpatient units didn't teach me how to sit with bad emotions, they

outright told me to 'distract myself' from bad emotions and if you weren't successful distracting yourself, to take some valium and you'd be alright. What this did was reduce my capacity to deal with everyday situations.

After a 4 week admission, I was discharged and tried to go on with my life like 'normal'. I went to work, where I was being bullied. I had just spent 4 weeks distracting myself from any bad emotion, and now I was in the real world, where I had to face it. I told work I had a migraine and left. I overdosed on a stash of medication I had and put myself in a coma. I spent a week in the intensive care unit.

Working in a risk framework can be dangerous, as practitioners we are not taught how to sit with risk and all the feelings it conjures up. As practitioners, we are taught that we sometimes need to protect people from themselves, and sometimes, we do (I'll discuss this some more in the next section). What practitioners need to learn, is how to manage risk, while still focusing on long term recovery, because there will be no recovery, if all we do is focus on the risk, and when there's no recovery, there will be endless risks.

Addressing Suicidal Ideation

I am a suicide survivor. I have had 3 serious attempts, and countless smaller attempts. I have been in 3 comas. My family and friends believed I would never make it out alive.

I had been assessed 10 days before my first serious suicide attempt. I was assessed as a low risk of suicide, according to my risk assessment. How wrong they were. Now in this assessment, I did not lie. I told them how distressed I was, but I was not taken seriously, and there were consequences for that.

My second serious suicide attempt happened in the inpatient unit. I continuously told them I wasn't ready for discharge. This was relayed repeatedly in my notes. I wasn't taken seriously, and they told me they were discharging me anyway. I wasn't heard, and this had serious consequences.

My third suicide attempt, was the one discussed above, 2 days after my release from the inpatient unit. My friend had called YAT to tell them he thought I was going to hurt myself. In my notes, they did not appear to take this seriously and took a bit of time to call me. By the time they did, it was too late.

I was listed as a 'chronic high risk of suicide', however, as mentioned above, people with Borderline Personality Disorder are viewed as 'manipulative' and 'attention seeking'. This meant, I (and my friends) were often not taken seriously. Any one of these attempts could have ended my life.

As a practitioner, I have worked with individuals who are suicidal. Once, I was with a consumer, and my senior worker. We had a lengthy discussion around the consumer's safety overnight. My senior worker began packing up her stuff, ready to leave. I stopped, and asked the consumer if they could guarantee their safety overnight, they said yes. I asked them if they were saying that because they were going to be safe, or if they were saying that because they wanted to leave. They told me it was because they wanted to leave, and so we stayed.

My senior worker commended me afterwards, acknowledging that I had sensed something that she hadn't. As a suicide survivor, I can sometimes see when someone is in that same position I was in, the times I had reached the end, and decided to take my own life.

The training we receive about suicide prevention is fairly basic, and it appears like we're only told to do these things to cover our own backsides if something goes wrong. What we're not told in that training, is to truly hear what this person is telling us, to empathise with them, to listen to our gut feelings. Sometimes it's not in the words someone is using, sometimes it's in the change in their behaviour. However, often, they are actively telling someone they need help and practitioners aren't listening.

Emergency Departments

I've spoken about emergency departments already, having been refused sutures to self-inflicted wounds that definitely needed sutures. Having sat in the waiting room, after hitting an artery because 'it's just superficial'. Refusing to go to emergency after I took bad GHB because I'd rather die than willingly go to an emergency department and deal with the horrible attitudes I was most definitely going to face.

These attitudes, are a massive problem if we want to reduce our suicide rate. As consumers, we are told to go to the emergency department if we are feeling suicidal. What we get, when we get there, is not an empathetic, compassionate person that wants to assist us. We are treated like 'attention seekers' and/or burdens on the health care system.

Emergency departments themselves are loud and busy and not the place you want to go to when you're feeling awful. To get to this loud and busy place, just to be treated awfully has serious consequences. People just don't go.

We need an alternative to emergency departments. We need community organisations running drop in centres for people who are feeling suicidal. Drop in centres that foster hope, that look for a person's strengths and values, and make recovery plans with people. There is more to us than our

suicidal ideation. We need people trained to bring out the rest of us in those moments of crisis, to hold the hope for us, to sit with us while we ride through the storm.

Recommendations

- Similar to needing to normalise conversations around mental health, we need to normalise conversations around suicidality. People need to feel safe discussing their thoughts. It is okay to feel that you want to take your own life, however, this is a crucial time to obtain the right support.
- We need to be less crisis-oriented. While we focus solely on risk, we are only ever going to have risk. Practitioners need training on how to manage risk, while maintaining future focused, it is the only way to break the cycle.
- We need more funding for PARCs. Unlike hospitals, PARC is therapeutic, and works with consumers towards their goals. Unlike hospital, consumers are not fully taken away from the outside world and they are encouraged to continue with their day to day routines.
- Practitioners need to be trained to really hear what people are saying. To listen to those feeling suicidal. They are the experts in their own lives. They know what they need in that moment. They don't always need 'saving from themselves'.
- We need training to be delivered by actual suicide survivors. We see and feel things that practitioners don't. We have insight that you can never learn about in a text book. This will save lives.
- We need community run drop-in centres, where people who are feeling suicidal can drop in, have recovery conversations and have staff properly trained to view people empathetically and compassionately while fostering hope.

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?

Honest Conversations about Mental Health

Recovery is not linear, it's not pretty and it's incredibly messy. We don't hear these stories. We hear stories of people who have 'overcome' their illnesses, like it's a benign tumour that we cut out and 'bam, fixed!'.

Recovery involves trialing a million different things until you find something that works for you. It's taking medication after medication, battling the horrific side effects and getting no real improvement in your mental health. It's going to several therapists until you find one that works for you. It's putting in really hard work that nobody sees, all the while, everyone has their two cents of advice to offer you. It's absolutely grueling, but we don't talk about this. We must start talking about this.

Every step forward we take is a step in the right direction. We should be celebrating these small steps. We should be walking alongside those struggling, reminding them that the path is long, but it's worth it. We should be having open and honest conversations with those struggling and their families and friends. We need to start being real about what recovery looks like, so we can celebrate all the small achievements.

When I was battling my way through my recovery journey, the only people I had telling me that it was going to be okay, were people that had read about me in a text book. I couldn't trust that, what did they know about what I was going through? I needed to hear that it was going to be alright, from someone that had walked a mile in my shoes, somebody that truly knew the pain I was in.

Further to this, the 'recovery talks' from practitioners in the field, were entirely focused around reducing my symptomology. When 'treatment' failed to alleviate my symptomology, I thought I was failing. I thought that because I was still suicidal, that I had failed in therapy. That because I had failed in therapy, that I was never going to get better. I believed that because I was never going to get better, that I should just end my life now. It was a never-ending cycle.

What I was not taught in therapy, was that it is okay to feel bad things. That sometimes, it's less about eliminating symptoms, and more about learning to live with them. The truth is, therapy and medication did little to alleviate my symptomology. This did not mean I was beyond help, it meant that I needed to learn to be kind to myself, I needed to learn how to live with the day-to-day symptoms of my illness, and I needed to learn, that I could still achieve greatness, while living with the symptoms of a mental health condition.

It Requires a Whole System Approach

Stigma, discrimination, the cost of services and the crisis orientated nature of services have already been discussed so I won't go over them again now. However, poor mental health does not occur in a vacuum, most people have a number of factors contributing to their poor mental health and we need a system wide overhaul.

If we are committed to good mental health we will fix: housing insecurity, poverty, family violence, sexism, racism, homophobia, etc. We will start treating issues with Alcohol and other drugs (AOD) as a health problem, not a criminal one, and we will start utilising therapeutic jurisprudence as an alternative to our hardline criminal justice system. It's all related and we can't claim to commit to tackling mental ill-health in our society without tackling these other failing systems. In my own recovery journey, I came into contact with a number of systems, all working independently of each other, towards different goals.

I was arrested 3 times before I began getting treatment for my mental health. I was lucky to have police officers who used their discretion to not charge me with a criminal offence, even though they could have. Not everyone is this lucky. Many people with a mental health condition bounce around the system, landing in the only place that will accept them, the criminal justice system. Instead of punishing those in clear need of help, we need to respond with compassion and real treatment options.

After being taught to run away from my feelings in inpatient units, I searched high and low, to find another way to run away from them, outside of the inpatient unit. I found illicit drugs. I was not a criminal, I had a mental health condition that I wasn't getting appropriate help with, and I fell in love with escaping my feelings through substances. Valium in hospital was my gateway, heroin was my first love. Treating people like me, as criminals for using, does nothing but cause harm. Drug dependency is a health problem, not a criminal one.

What I was trying to escape from was horrific trauma. Not only had the Child Protection system failed me as a child and allowed me to continue to suffer abuse, and not offer treatment after, but I was failed as an adult, by a system designed to fail women. I was raped by two different men when I was 19. I didn't report either, there was no point. I knew very much that the system I was a part of, did not hold men accountable for their actions. I knew that as a woman, I would be blamed, for being drunk, for what I was wearing, for being alone after dark.

Living through such significant traumatic events was hard, but there were no specialised services there when I needed them. To go to specialised sexual assault counselling there was a 3-6 month wait. Which doesn't seem like that big of a deal, however, when you're ready for counselling, you need it ASAP, before you psych yourself out of it again. By the time I got my first session, I was no longer able to talk about my trauma, and disengaged pretty quickly after waiting months to engage.

Further to this, the organisation I was referred to, wouldn't work to me the first time I was referred, because I was a 'high risk of suicide'. The reason I was so suicidal was because of the trauma of being sexually assaulted, but I couldn't access support to deal with these feelings, so I remained without appropriate treatment for quite a long time and continued to be 'a high risk of suicide'.

The literature into complex clients suggests that services like this are less likely to be concerned about the 'risk' a person poses to themselves or others, rather, organisations are concerned about the risk complex clients pose to the organisation's reputation – this needs to be addressed immediately. Services should not be able to turn away clients due to the risk to the service's reputation and there needs to be monitoring of services that turn away people in need.

Further to the trauma I experienced when I was a child, and at 19, I became homeless while I was in an inpatient unit. I had practitioners encouraging me to 'stay positive' and 'focus on my mental health', which was a little hard when I didn't know where I was going to sleep upon discharge. My mental health recovery felt impossible, given the number of other social problems I was facing at the time.

The moral of the story is, people don't live their lives in silos. If I am homeless, and/or experiencing family violence (or any number of other health or social problems), this is going to impact my mental health. What we need is a system that views people holistically, that looks at people's entire lives and says, 'what do you need here?'. We need systems that connect together for seamless service delivery, we need organisations that can speak to each other in order to coordinate care for those experiencing any number of life stressors.

The National Disability Insurance Scheme

The NDIS was not designed for mental health. It cannot offer a path to recovery. As a practitioner, what I have seen is entirely inappropriate options being offered to those experiencing mental ill-health. Need a psychologist? Nah, not our problem. Want a cleaner, sure! It won't help you get better, but your house will be nice and clean. This will cost the system substantially more in the long run.

The NDIS relies on a casualised workforce which is antithetical to the needs of people with a mental health condition, who require consistency in their support workers in order to establish a therapeutic working alliance. The NDIS offers less trained staff, especially regarding mental health conditions, which is so damaging to individuals long term.

The supports required for physical disabilities and psychosocial disability are incredibly different, yet this is not reflected in the NDIS price guide which outlines what services are available. We cannot rely on the NDIS to do any therapeutic or recovery work with consumers.

Recommendations

- We need to have honest conversations about mental health recovery. Once again, this should be taught in schools, but also by practitioners working with those experiencing mental ill-health.
- We need a whole system approach where we take into account all the things in a person's life that may be impacting their mental health.
- We need systems that communicate with each other for seamless service delivery and legislation which promotes this; like that seen in the *Human Services (Complex Clients) Act* 2009.
- We need to take NDIS out of the equation when viewing what supports are available for individuals with a mental health condition. The NDIS offers last resort funding for individuals that need assistance with practical tasks but does little to offer therapeutic, recovery focused supports.
- We need to fund specialist services (family violence, sexual assault, etc) so that individuals can access appropriate support in a timely manner. We need to train these organisations to be less risk adverse.
- There needs to be a system monitoring services who are turning away people. There needs to be safeguards in place so that those in need of support are not bounced around the system for lengthy periods of time without getting appropriate support.
- There needs to be a centralised access team, where people who need support can call, and be referred to appropriate services in an efficient manner.
- We need to view AOD as a health problem, not a criminal one, and have supports in place that facilitate AOD recovery alongside mental health recovery.
- We need to start offering rehabilitation to offenders with a mental health condition, rather than punishment. It is the only way to break the cycle of reoffending. Further, we need to ensure police officers are trained in the recognition of mental health conditions.

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

There are several factors that contribute to some communities experiencing poorer mental health, including but not limited to:

- Racism
- Homophobia
- Ongoing effects of colonisation

I think the last thing these communities need is another cis-gendered, hetero, white person speaking on behalf of them, so I won't. It is important that we tackle these issues at a political level, while taking time to listen to these communities, to really hear what they have to say, to hear what they need, and to tackle these issues from the bottom up. Top down approaches are not appropriate and have continued to fail to address these issues.

Other issues like housing, poverty, family violence, etc, have already been discussed so I will not go over them again. However, if we want to address communities who are facing poorer mental health outcomes, we need to address the underlying inequities in our society that are causing this. We need a whole of system approach.

Recommendations

- Listen to communities about these issues. They are the experts in their own lives.
- A whole of system approach to mental ill-health is required.

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

I spoke to my mum about this one. She said that nobody listened to her concerns, when my brother started acting out, when I started to get unwell. Mum said that 'could see everything that was going on, but [practitioners] had their information out of a book, and that was it'. Mum said that she tried on a number of occasions to facilitate different paths for my brother and I, but nobody ever took her opinion into account.

A secondary theme discussed by my mum was that there was no education provided. That my/my brother's conditions weren't explained and that as a result, my parents did not fully understand them. My mum reiterated that it would have been better to have had this information before we got sick. My sister reiterated this, saying that she just did not know what to look out for, that education surrounding mental health was so important, but not provided. My mum and sister spoke about the lack of conversations around mental health and how this hinders positive outcomes.

Recommendations

- Families/carers need better education around mental health conditions. This information needs to be provided as early as possible.
- Practitioners should be encouraged to take into consideration the views of families/carers.
- We need to reduce the stigma around mental health and start creating a normalcy around receiving treatment.

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

General Mental Health Staff

I briefly spoke about the importance of supporting the mental health workforce in earlier discussions around stigma and discrimination. I spoke about the effects of not supporting workers, which leads to burnout and I spoke about this flowing through to consumers.

In my first mental health job, I was thrown a bit by how independent everyone worked. We dealt with some pretty heavy stuff and I felt it was so important to deal with some of that stuff as a team. Prior to this job, I worked at a supermarket, where we were encouraged continuously to work as a team. However, in mental health, where the stakes are higher, I did not see much of this. Encouraging mental health staff to work as a team, takes the weight off the individual's shoulders, where it can be equally held by all members of the team, I think this is so important.

Staff burnout is very real, I've seen it, both as a consumer and as a practitioner. I've seen workers get so overwhelmed by their case load that they want to throw in the towel. But they aren't encouraged to rest, or ask for help, and managers don't recognise burnout until it's too late. As practitioners we all need to be taught what burnout looks like in its early phases. We need to know how to recognise it and be encouraged to do something about it when we see it.

Another issue for many working in the mental health field, is the pretty small pay cheques that come with working in this field. We do it because we're passionate, we care, and we want to make a difference. However, when so many of my colleagues are in debt, or are battling with the reality they'll never own property on what they earn, it gets pretty bleak. We work hard, in a stressful and demanding job, however the remuneration is small, and it needs to be reviewed.

Peer Workers and Practitioners with a Lived Experience

In my first job, I was told outright that I was not a peer worker, so therefore did not get support from my peers. But the truth is, as a practitioner with a lived experience of mental ill-health and recovery, my day to day experience as a practitioner is vastly different from someone without a lived experience.

As mentioned earlier I was constantly confronted with prejudiced and stigmatised views of my colleagues. If they talked like that about my diagnoses, I believed that's how they must feel about me. I was never offered any support to deal with these things and my manager never took my concerns seriously. It was an isolating experience.

When I began connecting with other workers with a lived experience things started to become a little easier for me, but I chose to connect with them on my own accord, and management was not supportive of it. Each organisation should have avenues for those with a lived experience to connect with one another, it makes us feel less isolated and better supported, and as a result, we do better work.

What is also important for peer workers, is to have a workforce where we feel heard. I once spoke up in a team meeting and said, 'as a consumer, I find the way you're talking to be really offensive'. What I got back was my colleague snapping at me, 'well, you don't speak for all consumers'. Again, management did nothing to assist; to make me feel supported, or to help me feel heard.

I've discussed remuneration already in above sections. However, I want to reiterate that if we really want a peer workforce, we need to start paying them a decent wage. I'm a lucky one, I have a Bachelor degree with honours to fall back on, I can work in non-peer specific roles. The truth is, as much as I'd like to work in a peer-specific role, the ones I have seen, get paid less than other jobs I can get with my qualifications. I have chosen non-peer specific roles, so that I can afford to pay my bills. If we truly value and respect peer workers as the experts that they are, we'll start paying them what they're worth.

Recommendations

- Mental health workers, especially peer workers, need better remuneration.
- We need better training for staff and managers to identify burnout and how to prevent it.
- Peer workers and practitioners with a lived experience need peer networks.
- Managers need to be trained on how to attract and retain peer workers and people with a lived experience as their day to day experiences are vastly different to workers without a lived experience.
- Encourage mental health providers to facilitate team-oriented workforces.

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?

I think tackling stigma and discrimination will automatically increase somebody's social and economic participation. I think more work needs to go into the workforce particularly. It's illegal to discriminate against someone because of their mental health, but it does not mean workplaces know what to do with someone who is experiencing mental ill health.

I'm one of the lucky ones, in the time since I was 15, there has only been 7 weeks where I have been unemployed. However, there was a good portion of that time that I wasn't actually working. I was lucky to have workplaces that accommodated this.

While they were accommodating of my time off, other than that, they didn't know much about mental health, how to help, or how to facilitate me returning to work. They often seemed lost, and simultaneously scared for my welfare and frustrated at me being constantly unwell.

I was at one workplace for almost 13 years, about 12 years in, I had a manager ask me what to do if I had a panic attack. He was the first manager that did this.

There is a lack of training around mental health in the workforce. For the most part of my employment history, my managers weren't practitioners, for many of my managers, I was the first person with a serious mental health condition that they had come across. It's not that they didn't want to help, they just didn't know how.

Recommendations

- There is an opportunity to increase social and economic participation by increasing the number of peer workers in our peer workforce.
- Organisations outside of the mental health field need proper mental health training. Some organisations complete mental health first aid, but this is a very limited course with little scope (it's also more about ticking boxes than working alongside those with a mental health condition). There should be workshops facilitated to reduce stigma and to increase employers' understandings of how to take care of employees experiencing mental ill health.
- Putting funding back into Community Mental Health and lowering the threshold for eligibility can help with this. Community Mental Health is more goal oriented work and for many people, their goal is to return to the workforce. Having a practitioner walk alongside them through this process can be the difference to whether they do return to work or not.

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?

As discussed earlier a whole of system approach is necessary. People do not live their lives in silos and therefore, their treatment should not be offered in silos.

A priority of this commission should be creating real safeguards against the abuse experienced by people getting mental health treatment.

A second would be to return funding to community mental health and to decrease the threshold for services.

A third, to take away the cap on Medicare subsidised appointments in somebody's mental health plan. The number of sessions you are entitled to should be based on individual circumstance.

Fourth, to increase funding to models like PARC that focus on rehabilitation and preventing hospital admissions.

Recommendations

- Take away the cap on Medicare funded psychology sessions and make sure they are fully subsidised, not partially.
- Return funding to community mental health and decrease the threshold for eligibility.
- Create a system that views individuals holistically rather than treating them in silos.
- Increase funding to PARC.

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

Research

While I was completing my thesis, I was sure of one thing. Australia does not prioritise research. If we are going to have a mental health system that works, we need to be up to date with current research; only we're not doing much at all.

My thesis was on complex clients, and there was little research I could reference from Australia. Relying on research from other countries is problematic. Different countries = different contexts. Just because something works overseas, does not mean it will work in Australia in our current political, social and economic context.

If we are going to have a system that works well, and continues to work well, we need to start funding research, so we can ensure our practice models are up to date.

Ongoing training

While funding research, we also need to fund ongoing training for practitioners in the field. I've met several practitioners who are quick to speak about their, '20 years experience' in the field, but what I don't hear from them is how they've continued to access training over that 20 years, how they pride themselves in working from current best practice models. I don't hear it, because it rarely happens.

The field has come a long way in 20 years, but many practitioners are not utilising current best practice. We need to make it mandatory for practitioners to continue to undertake professional development and training and there needs to be safeguards in place to ensure practitioners are complying with current best practice.

Transparent reporting

We need practitioners to be held accountable for their decisions. We need transparent, public reporting on the use of restraint (physical, mechanical and chemical), the use of seclusion, the use of involuntary treatment. Some of this will be touched on in the next section.

Recommendations

- Increase the funding for mental health research. This is vital if we want to see continued improvements in the mental health field.
- Provide funding for practitioners to continue to receive training throughout their professional careers.
- Implement safeguards to monitor practitioner professional development to ensure all practitioners are practicing using current best practice.
- We need public, transparent reporting on interventions that are harmful to people.

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

I'm disappointed that this commission did not ask specifically for instances of abuse/abuse of power in the questions asked. Giving consumers a platform to speak about the abuses that have happened to them, provides an opportunity for them to move on from these things. Further, it is absolutely vital that we address all abuses/abuses of power within the mental health system.

Rights, Assumed Capacity and Informed Consent

Under the *Mental Health Act* 2014, consumers are supposed to have an assumed capacity to make their own decisions regarding treatment. I have not seen this translate very well into practice. Practitioners often make decisions on behalf of consumers, even voluntary consumers.

I never had my rights explained to me. This is not something that happens regularly, and it should. I never had anybody explain what my involuntary treatment order meant, only that it meant I had to do what I was told. I was never taught how to challenge this. It was a huge breach of my human rights.

Despite having more practitioners than I could count over the years, I'm not sure a single one of them assumed that I had the capacity to make my own decisions. I was never given information about my treatment, I was just told that 'this might help', or 'we're going to try this'.

I was given medication after medication, often on multiple medications at once, often battling horrible side effects. These side effects were not explained to me prior to being prescribed a medication, they were just a very unpleasant surprise. I have only ever had one doctor (a GP) admit to me that there are long term side effects to psychiatric medication, this was after I challenged him. Not once, at any other time, was I told that there were long term side effects, including a shorter life span, parkinsonism, brain damage. These are side effects we should definitely know about if we are going to make an informed decision about what treatment we utilise.

Involuntary Treatment

We need to revisit involuntary treatment and have real safeguards in place to prevent forced treatment on individuals who are quite capable of deciding which treatment option is best for them. I've been put on involuntary treatment orders numerous times, all of these times it was decided that I was a danger to myself, and of course, on none of these occasions was I actually a danger to myself.

I was forcefully put in hospital to 'save me from myself' only, I didn't need saving. When I told practitioners that I did not intend on hurting myself, they decided that I was lying or 'not forthcoming with the truth', that I was going to hurt myself, and that they needed to protect me, from me.

As a practitioner, I attended a mental health tribunal with a consumer. The tribunal was adjourned, on Christmas eve, for 10 business days because the consumer had not been given a chance to review the treatment order. For 10 business days, over the Christmas period, the consumer was left in an inpatient unit, because the inpatient unit failed to go over some documentation with the consumer. This is not okay.

Having your rights taken away from you is traumatic and the impact this has on someone's wellbeing is ongoing. I understand it's unlikely that involuntary treatment will be removed completely, but we must have proper safeguards in place to ensure this power is not being abused.

Use of ECT

I was lucky enough to never have ECT forced on me, one of my friends from hospital did however, and it changed her life, for the worse. After getting ECT she couldn't even carry out a conversation anymore. She couldn't get through a whole sentence without forgetting what she was saying. It was awful to watch, somebody as bright as her, with so much potential, having her brain literally fried by people who were supposed to be helping her. The dangers and ongoing effects of ECT are well documented. What isn't documented (in non-biased studies) is the evidence that ECT is beneficial. It is archaic, and needs to go in the bin.

Use of Mechanical Restraints

I have been placed in restraints, more times that I could count. I am somebody who is quite capable of reason, however, it's a lot quicker to restrain somebody to the bed by their wrists and their ankles than it is to reason with them, and so, I was restrained, again, and again, and again, and again.

My mental health initially deteriorated after I was raped twice in a year. For me, restraining me was one of the most terrifying things you could do to me. Pinning me down to a bed, for you to do whatever you wanted to me, was incredibly re-traumatising. But nobody cared, for I wasn't a person, I was a number and the quicker they 'dealt with' me, the better.

Use of Chemical Restraint

Chemical restraint is another terrifying form of control, used far too often. But chemical restraint can look different than what you'd imagine (forcibly injecting someone to sedate them). What we don't have the statistics of, is how many people are heavily medicated, day to day, just to make them easier to deal with. And it happens, I've been that person, medicated so heavily on antipsychotics that I couldn't function day to day, so sedated that I was just too tired to hurt myself. I've seen plenty of people in the inpatient unit in the same position, but we don't discuss this, it's not even on anybody's radar. We must look into this.

Another form of chemical restraint that we don't look into is the overuse of PRN on the inpatient unit. Each time I went to a new inpatient unit, their initial response to me was to 'give me something to calm down'. It was easier to give me a benzo or a sleeping tablet than to sit with me for 10 minutes to talk through the fact that I had just been forcibly brought to hospital, again. Once again, there's no statistics on this, we're not looking into it, and we bloody should be.

Use of Seclusion

Now I am lucky enough that I was never put in seclusion. But it happens, a lot. VMIAC recently released a report on it and it's disgusting. Seclusion was more of a 'threat' to me than anything. Once, I was involuntarily admitted to an inpatient unit. In my notes from that stay, they wrote that they 'orientated' me to the ward. What that meant, was that they took me to the seclusion room, and told me that if I did not behave, that's where I'd be staying. It was a unit I had never been in before, they knew nothing about me, and yet, their initial reaction to me, was to threaten me into complicity. If it happened to me, I am sure it's happened to others.

Threatening someone with seclusion is not therapeutic, and it is not okay. Seclusion itself, like restraint, is overused. It's a 'quick fix' to a 'non-compliant' consumer. The use of seclusion needs to be thoroughly reviewed and there needs to be consequences for using seclusion inappropriately.

Safety in inpatient units

Another thing we need to talk about, is safety in inpatient units. I am lucky enough to have never been hurt in inpatient, but I've been in lockdown plenty of times. For somebody already traumatised, this was pretty scary, and there was never any follow up. It was a given that we'd be exposed to scary stuff in there and so we dealt with it on our own.

I once woke up to a lady at the end of my bed, screaming at me. When I went to get a nurse, they shrugged their shoulders and laughed, 'yeah, she does that'. They offered no assistance, they did not come out to resettle her, it was my problem to deal with.

Once, I was placed in an adult unit because there were no beds in the youth unit, everyone there was about two decades older than me. I went for a walk around the unit and was cornered by two men. I was lucky enough that somebody came around the corner, and I could quickly get away, but again, there was nothing done to make me safe on the unit.

Another time I went into an adult ward when there were no beds in youth. I was initially admitted to HDU. A nurse shook her head, and said, 'you can't wear that', pointing to my singlet. When I asked why, she told me 'there are men in here that will hurt you'. They gave me a hospital pajama top to wear over my singlet, to 'protect me'. When I got transferred into LDU, a different nurse told me I needed to put on pants as well, that I can't wear shorts either. So, I put on some hospital pajama pants. I was now terrified for my safety, and I had lost my identity under hospital pajamas. Nothing was done to reassure me, it was a given that I was unsafe in hospital, ironically, the place I was sent to 'keep me safe'.

Again, I'm one of the lucky ones, I was never actually hurt. A friend of mine woke up to someone on top of her, many people have been assaulted. Nothing is done to protect us.

Recommendations

- Abolish ECT.
- Implement a higher threshold for involuntary treatment and implement real safeguards to prevent unnecessary involuntary treatment.
- Doctors, psychiatrists should be required to obtain proper informed consent from consumers by providing all the information about side effects/long term effects of different treatments.
- Implement proper safeguards to protect people from abuse/abuse of power.
- Review the use of mechanical restraint.
- Review the use of all forms of chemical restraint.
- Review the use of seclusion.
- Put proper safety mechanisms in place in inpatient units.
- Have separate male/female wards.
- Youth should never be placed in adult wards.

Conclusion

We've waited for this Royal Commission for a long time. So many people have suffered due to the failings of the current system. For decades, we have treated those experiencing mental ill-health as second class citizens.

The deinstitutionalisation movement, carried by a human rights movement was a pivotal time in our history. However, calls for community supports have been left unanswered. These unanswered calls in the community, continue to be human rights issue. Those experiencing mental ill-health are not second class citizens and deserve every opportunity to live happy and fulfilling lives. Inappropriate mental health support is a human rights violation.

There are still several harmful practices utilised by practitioners. We still overuse restraint, seclusion and involuntary treatment. We still use ECT. These 'practices' are traumatic and have ongoing effects on the individual. We need to ensure that these 'practices' are monitored and have proper safeguards surrounding them and real consequences for misusing them.

We need to provide proper education around mental health from a young age. Every single person in society needs to understand mental health and needs to be able to recognise the signs that themselves, or somebody around them, is struggling.

We need to normalise seeking treatment for mental health. Going to a therapist for your mental health needs to be as normal as going to the GP when you have a cold. We need to fund early intervention treatments to reflect this. There should not be a cap on subsidised psychology sessions, just as there is no cap on GP appointments. If we want seeking help to be treated as normal, we need to start funding it to reflect this.

We need to put back in funding to Community Mental Health and we need to lower the threshold for eligibility. We need to increase the funding to PARCs. We need to create community run drop in centres for those experiencing suicidal ideation. We need to stop focusing on deficits, and start funding recovery oriented services if we are going to claim a commitment to early intervention.

We must address mental ill-health holistically. People do not live their lives in silos and cannot be treated like they do. The mental health system needs to work collaboratively with other sectors; family violence, housing, alcohol and other drugs, etc. We must start addressing the things that negatively impact on people's mental health, income disparities, insecure housing, family violence, sexual assault, racism, homophobia, the ongoing effects of colonisation. Good mental health requires a whole of system response.

We must listen to those struggling. Prioritise the voices from people with a lived experience and individuals from marginalised communities. They are the true experts in this. Listen to them, truly hear what they are saying, and implement their suggestions.

This royal commission is long overdue. I hope that it exposes the structural failings of our archaic mental health system. I hope there are clear and appropriate recommendations at the conclusion. I hope that we create some tangible systemic change.

We have failed those experiencing mental ill health for too long. We have enforced harmful interventions and inflicted further trauma on those already suffering. It is too late for so many people who have lost their lives while fighting their way through this system; but we must fight for them still, and every person about to walk down that same, dark, isolating path.

I believe we can create a better system. We can and must create a society that deals with mental health openly and empathetically and promotes recovery and inclusivity. I will continue to battle my demons every day but I will also continue to fight for a better system because we can do better than this.