

Your contribution

I have worked as a mental health advocate for over 20 years. I have spoken with and provided advocacy support to literally thousands of mental health consumers at all stages of their journey through mental health services and have worked in metropolitan, regional and rural areas. The views expressed here are only my own and derive from both my personal and professional experiences.

I submit:

1. The medical practice of psychiatry exists to treat “mental illness” and has been by far the predominant treatment modality since its existence, particularly of people diagnosed with “severe mental illness”. The medical profession is a very strong lobby group for itself, with plenty of funding to spend on quietening (or drowning out) other voices. Likewise, the pharmaceutical industry holds considerable advocacy power to influence the opinions of the whole community, as well as all people involved in the health system. It is within this environment that the Royal Commission has been charged with the task of making recommendations for *radical reform* of the mental health service system. To do so the Commission will need to attempt to subdue the voices of these most powerful lobbies.
2. The voices of mental health consumers are often not heard and are frequently diminished. Many people’s voices have been permanently silenced through suicide. Many others have effectively been silenced by not having their important life experiences believed or validated, often when they were very young. Mental health consumers have a “credibility” problem, whereby (because some people at some times express unusual beliefs or experiences) people are very frequently not listened to, not believed and not trusted to be truthful. As a member of the mental health consumer movement, it has been devastating to see how the voices of Victoria’s mental health consumers are being silenced within the Royal Commission itself. It is essential that this Royal Commission discriminates in favour of the mental health consumers who contribute to the work of the Commission, knowing that as well as speaking our own truth, we are at least attempting to be the voices for many others who won’t be heard. A certain rhetoric pervades mental health services around the more outspoken consumers not being representative of the whole consumer community, which premise I wholly reject. Consumer leaders are articulate about how it feels to be medicated against your will, or not believed by service providers, or to be punished for self-harming, and our perspectives reflect our experiences. Most improvements to mental health service delivery have been led by consumer advocates and activists (eg. recovery-focused care, supported decision-making, service co-design, trauma-informed care, reduction in restrictive interventions and highlighting issues regarding women’s safety within mental health services), yet we continue to be excluded from the conversation that continues to be dominated by psychiatry.
3. There is a high level of fear among the consumer community that this Royal Commission will conclude with recommendations that funding is increased, and more psychiatric beds are provided. It is critically important that this Royal Commission results in a radical, brave and *different* path towards greater mental health for the whole community.
4. The evidence equating serious mental health issues with experiences of abuse or trauma continues to grow. Every member of this society, including mental health consumers, has

been provided with substantial “information” about the nature of “mental illness” from the perspective of the medical profession, and the medications available to treat it, and many consumers accept the rhetoric that “it’s an illness like any other,” “it’s a chemical imbalance in the brain,” or “it’s in your genes.” The result is that people often don’t associate their traumatic life experiences with later mental health issues, effectively denying them information about potentially alternative ways to address their issues as well as an alternative, and potentially more empowering, perception of themselves and their life challenges. Our system supports people with great power and privilege forcing debilitating and life-shortening medications onto survivors of abuse and trauma.

5. The medical paradigm of “mental illness” has failed to address issues such as discrimination against mental health consumers, and the (now mostly historical) language of “chemical imbalance in the brain” has effectively stifled broader conversations about trauma, wellbeing, and the social determinants of (mental) health. On the whole, psychiatry has not delivered better outcomes for consumers since medications became available in the 1950s, and people living with severe challenges to their mental health continue to die on average one or two decades earlier than people not subject to psychiatric treatment. Evidence tells us that people’s physical health issues are often overlooked by psychiatric services. Consumers frequently talk about the debilitating side-effects caused by their treatment (and sadly are often not believed that these are real). Many people are genuinely distressed by the fact that treatments have caused obesity or diabetes and shortened their life expectancy, and these concerns are often dismissed by clinicians as more related to a person’s genetic background, caused by eating too much or able to be overcome if the person exercised more. On the whole the people prescribing these medications have not experienced how they can feel to the human body, yet they are in such a strong position of power that they are free to disregard or diminish consumers’ reported concerns.
6. Substantive *radical* change to the way mental health care and treatment is delivered will need the support of a community that is well informed and willing to commit to a different way to think about mental health issues. We need to start a dialogue with the Victorian community, on the back of recent conversations about the mental health issues experienced by victims/survivors of childhood sexual assault, victims/survivors of family violence, war veterans, people who have experienced torture, and members of the GLBTIQ community about mental health issues that is more nuanced than “there’s treatment (ie. medication) available”. We all need to more closely equate mental health challenges with other life challenges, including poverty, homelessness, discrimination and bullying, life transitions, social isolation ... and we need to support the community to understand that the “person with schizophrenia” is most likely a survivor of institutional childhood sexual assault or other violent life experience.
7. Almost everyone experiences mental health challenges at some stage in their life. People find a range of ways to overcome or manage these challenges, including many who reach out for “professional” support. I contend: (a) if an individual’s mental health challenges aren’t addressed they will worsen; (b) practically any form of support is cheaper than psychiatry; (c) we want the Victorian community to be as mentally healthy as possible for many social and economic reasons; and (d) the mental health burden of society (and therefore the burden on services) is growing year on year. One problem with the medical paradigm as the primary form of treatment of “severe mental health challenges” is that it’s very expensive, and it sucks up most of the money allocated to public mental health care and treatment. This will only increase as the burden of mental health issues continues to

increase. Victoria would be best served by a substantial investment in a very broad grassroots (non-clinical) community support system that is available to anyone seeking support for their life or mental health challenges, without significant waiting lists, and regardless of where they are both geographically and on their “mental health” journey. We need a safe, non-clinical “no wrong door” network of community support options that are designed by local communities to respond to local needs. I believe that such a strategy would significantly reduce the burden on clinical mental health services.

8. A major issue with our current system is that people can often not access public clinical mental health services when they identify that they need support, and we have all heard the stories of people who are told to come back if it gets worse (which it often does). Efforts to reduce the need for psychiatric services would be financially beneficial, enabling funding for many more local community initiatives aimed at building healthy communities and support for individuals. To the extent that this strategy can reduce the numbers of people needing to access psychiatric services, it would also have great benefits to individuals in terms of reducing the trauma created both by more serious mental health issues, as well as that inflicted on many people by their clinical experience.
9. Consumer-run and -led services are favoured by many consumers as providing community support in ways that can feel safer and more empowering than services run by “professionals”, as well as sometimes being able to provide a broader perspective beyond the purely medical one for people to consider their mental health challenges, needs and preferences. I advocate that a recommendation be made around the government committing to fund mental health peer-led community groups and services right across Victoria. Funding criteria should be broad enough to satisfy the needs of each group, in line with the recognition that it’s better (and very cost-effective for the service system relative to psychiatry) for people to be offered peer support and local networks to support good mental health rather than entering or continuing to access the more formal service system. Consumers need to be supported and encouraged to be innovative, to deepen our understanding of how to respond to mental health challenges in ways that are effective, empowering and do no harm.
10. The Mental Health Act 2014 is now 5 years old and we are seeing it fail in many of its core intentions. Most people continue to receive psychiatric treatment in the same way it was delivered before 2014. While people who are well informed of their rights and able to assert them (including with the support of advocacy and other mechanisms built into the Act) *may* find a clinical service system more willing to accommodate their perspectives and preferences *if they align with psychiatric perspectives and offerings*, by far the majority of people are still subject to a system that doesn’t see the value of informing people of their rights (so very frequently fails to do so) and doesn’t uphold either the Principles of the Mental Health Act or its stipulations.
11. I advocate abolishing compulsory mental health treatment altogether, thus abrogating the need for a Mental Health Act. I believe that the removal of compulsory treatment could have the following types of consequences: (a) people would no longer fear being treated against their will, meaning that they may be more likely to seek support and treatment for their mental health concerns; (b) people would be more likely to have an experience of service where they felt heard and treated with respect, and be more likely to be provided with information about options available to meet their support and treatment needs; (c) clinicians and others working within the mental health service system may find more collaborative ways of working with people if the option of compulsory treatment is removed.

This could lead to enhanced job satisfaction for many clinical staff, thus going some way to overcome the issues the sector has in attracting and keeping staff; (d) evidence tells us that most incidences of violence against mental health workers by consumers happens in the context of staff trying to force a consumer to do something against their will. The abolition of this treatment regime would have the effect of making the mental health service system safer for the staff that work within it as well as for the consumers who access it. The reality is that we can't know the consequences of such a step without trying it. I advocate that a pilot be established whereby one metropolitan and one rural mental health service be supported to gradually move towards a non-compulsory trial.

12. In my view an outstanding aspect of our current mental health service system is the high element of "randomness" or chance in the treatment pathway of an individual. While we know that it is not possible for clinicians to assess risk beyond putting a large percentage of people in a "high risk" category, we continue to rely on copious numbers of risk assessments, which purport to support clinicians to make more standardised decisions about individuals. Yet a myriad of factors such as the particular knowledge bases or biases of individual practitioners, the "likeability" of the consumer, the level of gratitude or otherwise for their treatment an individual expresses, as well as demographics such as age, cultural background and gender mean that it is impossible to predict how any individual will be treated by mental health services. So some people receive a high quality of service while others feel worse off due to their treatment and still others are rejected outright from gaining access.
13. In this environment, it's not surprising that in many instances there is a mutual lack of trust between consumers and service providers. The point in time when a person enters clinical mental health treatment may be one where the person feels isolated, untrusting or suspicious anyway. I believe that benefits would accrue to both sides of this relationship if clinicians were trained to reach out, listen to and be responsive to individuals' defined needs, rather than placing them on a compulsory order.
14. If we are to continue with a service system that relies on compulsory orders to enforce treatment, it is imperative that this system is seen to be fair and acting according the letter of the law. If people are dismissed or even laughed at for trying to assert their rights under the Mental Health Act (a common experience), the resulting sense of despair and worthlessness can be devastating for individuals. If we assume that the main purpose of clinical mental health treatment is to reduce human suffering caused by "mental illness" (is it?), the service system cannot justify the human rights abuses and harm done to individuals by service providers that behave as if they are above the law.
15. While the majority of people working within clinical mental health services are caring, responsible and responsive to consumers' rights and expressed preferences, I believe that a sizeable minority hold values that mean they are willing to assert their power over consumers with the justification that it is "in their best interests". The psychological impact of people losing this sense of agency over their own life choices and decisions is not well acknowledged by the mental health service system, but is well recognised within the recovery paradigm, which is explicitly supported in the Mental Health Act. People are routinely not told about their rights, not provided with documents and reports within timeframes specified in the MHA, advised about "emergency ECT" hearings with such short notice that they have no ability to access legal support, and not provided with information (let alone the ability to be involved in decisions as specified in the Principles of the Act) about their treatment plan or discharge planning. People who report debilitating medication

side-effects are often not believed or the debilitating effects are diminished by clinical staff. A substantial majority of consumers advise that they have never been asked about their traumatic life experiences by their clinical treating team, and many report that they are disbelieved or doubted if they do attempt to talk about what distresses them. All these things mean that a large number of mental health consumers feel that their lives have been taken over by services, that their perspectives have no value, and their traumatic life experiences are irrelevant to those providing mental health support. These things frequently mean that people (particularly those treated on a compulsory order) ultimately feel that they are worse off and further traumatised by their experiences of clinical mental health services.

16. The problem with clinical mental health services has always been about the culture that pervades this part of the service system. Despite numerous efforts to address this issue, with programs such as Safe Wards as well as legislating for change and providing education and training to staff, the Mental Health Act continues to be breached every day with no consequence for practitioners or services. Mental health services have had ample opportunity to change their practice and to develop innovative, collaborative and inclusive ways of working with their clients and for a large number of people they have failed to do this. I advocate that the Commission make a recommendation that all mental health practitioners are provided with mandatory (re)education about their responsibilities under the Mental Health Act and, once this education has been provided, the penalties for service noncompliance are serious and enforced.
17. Consumer lived experience positions need to continue to grow across the service system. Peer workers can be effective in a wide range of service environments and are very gratefully received by consumers. We need to recognise the valuable expertise of people who identify as having lived experience of mental health challenges, and provide funding to support people to partake in peer-designed and -delivered training to grow this valuable workforce.
18. Considering the likelihood that compulsory treatment will continue post this Royal Commission, I submit that at a minimum, (a) s.71 should be repealed; (b) Advance Statements should be legally enforceable; and (c) bodies such as the Mental Health Complaints Commissioner, the Mental Health Tribunal, the Office of the Chief Psychiatrist and the Second Psychiatric Opinion Service are evaluated and their remit strengthened where necessary to ensure they play an assertive role in ensuring the Mental Health Act is upheld. I further submit that the Independent Mental Health Advocacy service be funded to provide an "opt-out" service, so that anyone experiencing compulsory treatment has the option of the support of a knowledgeable advocate to navigate the service system and understand and uphold their rights.