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Dear Commissioners,

Re: Royal Commission into Victoria's mental health system.

By way of background, I am a psychiatrist, consumer, academic, writer, media broadcaster and clinician. I have worked in our system for about 30 years in various places including the Austin, Alfred, Peter Mac, Melbourne and Monash Universities, plus a few spots interstate and overseas.

I am currently the director of psychosocial oncology at Peter Mac (psychiatry, psychology and social work) and the director of the department of cancer experiences research at the Sir Peter MacCallum Cancer Institute. I am an honorary clinical professor at the University of Melbourne.

I've suffered depression and accessed services, and written and spoken about it publically – most recently in my book "Mental – everything you never knew you needed to know about mental health" co-written with [REDACTED].

I have also engaged with the media for over 20 years, as a co-host of "Radiotherapy" on 3RRR and "Writs & Cures" on ABC Melbourne. Recently I helped produce, and hosted, "How mad are you" – a two-part documentary on mental health stigma for SBS TV.

I write this submission representing only my own views – not those of the various institutions I work with. Of note, I am not addressing all the questions you have asked, just the ones where I believe I have something that is worthwhile to add.

I welcome this Royal Commission with open arms. It is long overdue. The system is failing to meet demand, often inadequate and lacking an evidence-based plan to improve. Despite amazing staff, consumers and carers who have worked tirelessly to fix it, our success has not kept up with demand.

Using the questions you have asked:

1. What are my suggestions to improve the communities understanding of mental illness and reduce stigma?
  - a. I believe progress in stigma reduction has been impressive in the last 20 years. Not even doctors knew enough about mental illness 20 years ago – now even footballers are aware. I believe the engagement with the arts and sports community has been the driver, along with organisations such as BeyondBlue.
  - b. Nevertheless, more media and community involvement is always welcome because the battle is far from won. The Sane media guidelines are great, but a little too paternalistic – let's just open the conversation and stop pretending the public can't cope. My own approach has been to engage with the media, and whilst I think this helps, I don't think the public is very interested in what experts say –

it's far better to put resources into organisations that the public engages with – especially the arts and sports.

2. What is and isn't working in the current system?
  - a. What is working? An enormous amount really. Hundreds of thousands of people are treated each year and most do very well – most people get better, many access help easily, mostly the system is compassionate, and most of the workers are well trained and supported. But given the suicide rate, the numbers who cannot access help and the widespread dissatisfaction with our system – clearly more is needed.
  - b. What isn't working?
    - i. **Access** - the system is far too complex and variable depending on which area you live in. Even after 30 years working in the system, I am constantly confused and making a half dozen phone calls to find a service for a patient. The system MUST mirror the physical health system that we all understand. Efforts to combine the physical and mental health systems have either not gone far enough or failed. This includes:
      - Remove the discriminatory area based system – currently you must access the services in the suburb that you live. This is clearly discriminatory against lower socio economic groups – guess which areas have the most services? The rich suburbs. Just like physical health – the consumer should have choice. They should be able to choose the hospital or service they wish to attend. The area based system is purely used to limit services – especially to the poor.
      - Stop the erosion of expertise. Slowly over the past two decades, expertise has been lost for the sake of savings. If you attend any physical health service you will see a team including doctors, nurses, social workers etc. In mental health, this is not the case. Most assessments are done by nursing staff alone, usually with only sign off by doctors who haven't actually seen the patient. Assessment and treatment planning are the cornerstone of healthcare – and must be done by a team that includes actual (not virtual) medical input.
      - Integrate mental health with physical health. The most likely time in your life to get a mental health problem is during a physical illness. The most likely place for a person who has attempted suicide to be assessed is in a general medical setting. The most likely place to first encounter a mental health clinician is in a medical service. Despite this we have slowly defunded general hospital mental health services (often called consultation-liaison services). This is the greatest missed opportunity to engage mental health patients. Some of our major health services, treating serious problems like cancer, have NO mental health services at all. Hardly any have adequate staffing levels. Furthermore, it is a major missed opportunity to show non-mental health staff how to practice mental health. It would be the

best single thing we could do to aid early intervention.

- ii. **Treatment options** — our system is heavily biased towards pharmacological options. Medicines are relatively cheap and many are moderately effective. But to provide them without adequate psychological and social support is often a waste of time, and more seriously, and cruel lie sold to patient – the idea that medicines alone will fix their problem is well known to be false.

We clearly need better access to psychological and social support – provided by experts – psychologists for the specific psychological therapies and social workers for the social support (which includes family support, counselling, financial/housing support). These are manifestly inadequate everywhere. Psychologists are reasonably available in the community (through Better Access programs) but virtually invisible in hospitals. Social workers are reasonably available in hospitals, but virtually invisible in communities.

All the early detection, access and coordination is useless unless we have evidence based treatments to offer. Seriously, right now, we are mostly only offering medications – which we know only partly work, or do nothing at all, in the absence of adequate psychosocial support.

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

I've thought a lot about suicide. I've assessed over 1000 people who have attempted suicide. I was Head of a large Crisis and Assessment Team in Melbourne (Alfred Health) for years. I chaired the Vic Health Department External Consultative Committee on Suicide. My best friend from childhood died by suicide. I considered suicide when I was depressed. I've written articles and researched on suicide.

Despite this I lack confidence in my answers.

I believe suicide is a part of being mentally unwell. Just like some people die from cancer, some will die from mental illness. But just like in cancer, through prevention, early intervention and better treatments we could dramatically reduce the death rate.

I believe not all suicide is due to mental illness – voluntary assisted dying is a rational choice to end life – people should be free to end their life if they are rational and capable of making the decision.

If there was one thing I would highlight, it is the lack of solid research in mental health.

There is not much in suicide prevention that is based on solid evidence. Lots of conjecture and small studies that give tiny clues – but not much more. And this is despite suicide being the commonest cause of death in Australia up until the age of about 45 for both men and women! Again, sorry to harp on about the physical health system, but if this were cancer or an infection it would be declared a national emergency and millions would be poured into research. The reality is that the percentage of research dollars spent on mental health and suicide is a tiny in comparison to the scale of the problem.

My only suggestion here is to do the actual research. Not just in suicide, but in all areas of mental health. Until we develop strong, sustainable and successful research community around mental health, we will continue to be reduced to providing 'best guess' evidence and we will need another royal commission in about ten years. Most clinicians who wish to do research are prevented in Victoria because of a lack of research positions and support for research. We have great examples in physical health such as the WEHI or the Doherty Institute – we need a similar institute to lead the way in mental health. Also, put pressure on the NHMRC and similar groups to ask why they don't fund mental health proportionately. Ask the universities similar questions.

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

There is no doubt we fail families and carers. I once worked in India and despite their obviously limited system, one thing that I admired was their insistence that a family member stay with each mental health inpatient throughout their hospital admission to learn and understand how to help their loved one.

There are a few things we should urgently do to help families and careers – and they will also help the consumers.

First, develop simple and robust consumer and carer feedback systems and make the results public and available in real time. Just like google reviews, but for health care. Models already exist in other countries. Our health communities have been far too resistant, worrying the data will be misused, but in the process failing to embrace this great opportunity to improve our services through honest feedback.

Next, along with consumers, we should engage families and carers with the mental health system so we hear their voice in our planning and service development. Ensure they are represented at all levels of management from the board to the local committees, and NOT in voluntary roles, but as paid members of the team like everyone else around the table.

Finally, give a stronger voice to families in our mental health acts. This has already been done in the most recent mental health act, but didn't go far enough. Next of kin should have the final say around decisions like ECT, not the review board. In general health, the family has the ultimate control, even over life or death when their loved one has an illness that renders them unable to make decisions. It should be no different for mental health.

In summary, the mental health system is full of problems, mostly related to underfunding and patchy, ill-coordinated and poorly evaluated service development. In terms of the care system – our community and inpatient services – most are great, but change is needed.

Whilst the system has improved dramatically over the past 20 years, the improvements have not kept up with the pace of community awareness. In a sense, we uncovered an epidemic, but failed to provide answers, and quite rightly the community is now demanding action.

Remove the area based system – it's discriminatory and is used as an excuse to limit services. Stop the erosion of expertise for the sake of saving money – medical staff must be involved in all assessments, therapy should be done by psychologists, social interventions by social workers, nursing roles according to expertise, and so on for the other expert allied health groups.

Next, put the services where they are most needed, which is where sick people are being treated – hospitals, community health centres, GP practices – integrate mental and physical health. Not just co-locate (the cheap, pretend solution) but integrate; not only because physical and mental health problems go hand in hand, but because this will reduce stigma and stop the gross differences in levels of services provided to the two groups.

Engage consumers, families and carers in the system. Give them a voice at the management level with paid positions. Allow feedback and reviews and outcome data to be publically available in real time. Give them greater autonomy and control to direct care and make decisions.

And finally, apologies for the brevity of this submission. I returned from 5 months of travel just last night to discover the deadline was today. If you require further information, please contact me.

Best wishes for this important task.

Regards

Steve Ellen