2019 Submission - Royal Commission into Victoria's Mental Health System

Organisation Name SUB. 0002.0012.0009
N/A

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What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"Talk bluntly and openly about the risk of suicide. Say the word suicide. Be explicit that it is a risk and that people at risk of suicide must have constant care. Do not use euphemisms. Do not just say ""they cannot be left alone"" or ""they need constant care."" Do not deprive patient's families of the truth - in terms of documented suicide risks."

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
"This was not a problem in my family's experience - because the plummet was so rapid. The problem was supporting the person in the long term. I know - from the experience of my young adult child - how long it takes to recover from Major Depression. In my son's case, it took more than a year - 5 years of seeing a psychiatrist, taking anti-depressants, close attention from family. And yet, in my sister's case - her medical team led the immediate and extended family to believe she has all but recovered. ECT was used as a quick fix - and was presented as a treatment to her Depression. It was not - and it is not meant to be. ECT is a short-term fix in a very long-term programme. The medical profession is not set up for long term treatments - it does not practice it, and it does not reinforce to families how long-term the recovery will be. Everyone wants a short-term fix in our fast-paced world. No one wants to have to quit work, quit obligations and focus on caring. No one wants to be told - you need to care for this person closely for a very long time if you want them to recover. This is exactly what I had to do to care for my son. This is what no-one did to care for my sister. My son is alive more than 5 years later. My sister is dead."

What is already working well and what can be done better to prevent suicide?
"Stop pretending suicidality is a brief moment in a mentally ill person's life that can be solved with quick-fix problems. Start talking about how long it takes to recover. Start recognising the kind of care that is needed for a person to overcome mental illness - in this case, I am talking about Major Depression. Stop pretending drugs and ECT can fix depression. Stop putting people into clinics for a quick course of ECT, then letting them out and pretending that the brief afterglow of ECT - brought about by memory loss - has fixed all the problems. And stop the over-treatment with ECT of women. "

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.
"Good long-term mental health comes from good support. The best support comes from families. I quit my job to look after my son. There is no way the state can provide the kind of long-term support that is needed - instead, it should provide extended support to families, and recognition of the kind of care that is required. People with severe mental illnesses need a constant close

companion - someone who loves them and who lets them know they will walk with them, no matter how long the road. Give support to families. Encourage people to take time off work - extended time - to support their loved one. "

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

"Women are the recipients of ECT at a far greater level than men. So much talk about gender imbalance - but never a word said about this particular imbalance. Why is this? Women are usually the carers - who cares for the carers? Men need women to get better quickly. ECT seems to promise this magical quick-fix. It's not. It's a short-term solution in very extreme cases - and the effects are temporary. I add this description of ECT: Decades ago, Ollie May Bozarth, a psychiatric survivor, (1976) dubbed electroshock a gentlemans way to beat up a woman, and there appears to be merit to this description. Although the medicalization camouflages the assault, overwhelmingly electroshock constitutes an assault on womens memory, brains, integral being. And this being the case, electroshock may be meaningfully theorized as a form of violence against women. Add all this together and what emerges is a picture of ECT functioning to eradicate thoughts and skills, to punish, to threaten those given it and those witnessing it, and to silence objection. What emerges, in other words, is a formidable and comprehensive method of social control. The fact that such control is primarily exercised over women would raise the question of gender role enforcement. A number of interviewees spoke of refraining from expressing problems to their husbands, for fear of a resumption of medical-marital control of their lives . . . for fear of reprisal in the form of ECT. Broader ways in which husbands are implicated in the medical marital web of control include signing for consent, pressuring wives to sign for consent, suggesting shock, acting as a spy for the shock doctor, advising the doctor of bad behavior, and threatening to report noncompliance. The world really is fundamentally unsafe for women, especially women pronounced mad. And so, as many women realize, it is best to fit in, to play a role."

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

Encourage people to take leave to support family members. Appreciate the kind of long-term care and committment that recovery demands.

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

"There needs to be a more level playing field between doctors, nurses, patients, family members. Doctors need to listen. They need to appreciate that they can get things wrong and misinterpret family relationships. Doctors need to acknowledge the likelihood of making an error with a patient with mental health conditions. They need to be upfront and truthful. "

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 am talking about Major Depression here - and its recovery. Acknowledge that many people experience long periods of mental illness. Make it acceptable to recover. Make it acceptable NOT to have to do anything to contribute to ""economic participation"" while you are recovering. Work is NOT everything. Recovery demands some withdrawal and a gradual reconnection with social and

economic activities."

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
N/A

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
N/A

Is there anything else you would like to share with the Royal Commission?
Yes. I would like some transparency about the rate of ECT treatments in Victoria. Who monitors this? Where is the publically available information? Who decides what is best practice? Why do doctors in Victoria continue to use ECT in a way that is NOT supported by research? Where can I find a statement of best practice? Why are the decisions of the Mental Health Tribunal in complete contrast to existing practice of treating doctors? My sister was given ECT treatment on her first admission to a mental health facility - [redacted]. She had not had a sustained course of a single anti-depressant. She had multiple significant stressors in her life. Why was ECT even considered in this case? I note a decision of the Victorian Mental Health Tribunal in a case with similar circumstances that options other than ECT needed to be explored SBW [2014] VMHT 43 (24 September 2014). Why didn't the treating doctor explore other options? The treating doctor in my sister's case was preoccupied with my sister's private health care. She clearly booked her in for the purpose of ECT - without saying so when she was admitted. What is the link between private health care - length of stay - ECT treatment? Who is profiting from this unnecessary treatment? Why is it being supported throughout the profession? ECT is being used as a quick fix to treat patients - especially women - who need long-term solutions. It suits doctors. It suits men. It is profiting someone. It is a hushed-up scandal.