

Thank you for the opportunity to make a submission to this inquiry. I am a 41-year-old woman and a survivor of childhood abuse within a church setting. I am also a survivor of the Australian mental health system. I now live with very significant trauma-related mental health issues. While these issues originally stemmed from the childhood abuse, my experiences within the mental health system, as well as other systems such as the welfare system, now impact my life far more than those events of my childhood.

Reconceptualising “Mental Illness”

Based on my experiences, I believe the fundamental problem with the Australian mental health system is that it begins with the question of *what is wrong with you*, rather than with the question of *what happened to you*. It is well recognised that most people in acute mental health settings have a history of complex trauma (Jennings, 2004; Sweeney, Clement, Filson, & Kennedy, 2016). Complex trauma refers to repeated extreme interpersonal trauma such as childhood abuse and neglect, domestic violence and sexual and physical assault (Blue Knot Foundation, 2012).

Given this high prevalence of complex trauma, I believe the most cost-effective way of supporting people who have been given a psychiatric diagnosis, would be to invest money in developing genuinely trauma-informed services. Currently, it seems to me that the term “trauma informed” is a catch phrase, which is thrown around without most people truly understanding what it means. I am not sure that the general public is aware that in Australia, in 2019, practices such as seclusion and physical and chemical restraint continue to occur in public inpatient psychiatric units. While steps are being taken to reduce the incidence of seclusion and restraint, progress in this area is slow. Moreover, while the use of such overtly harmful practices is reducing, a culture wherein consumers routinely experience disempowerment and punitive responses from mental health staff persists. Consequently, rather than being places of healing, mental health units continue to be places of re-traumatization, which in turn reduces people’s capacity to fully engage in society.

For several decades, the dominant message regarding mental illness has been that it is just like a physical illness. We have been told that illnesses such as schizophrenia and depression are due to a chemical imbalance and that drugs are used to correct this imbalance. However, whereas the person with diabetes uses a blood test to check their insulin levels and then administers the correct amount of insulin based on the results of this test, there is no such blood test to assess the levels of brain chemicals such as dopamine or serotonin. Indeed, the idea that these chemicals are a causal factor in mental illness remains an unsubstantiated hypothesis (McLaren, 2013).

Drugs undoubtedly have an impact on brain chemistry. However, changing brain chemistry, and correcting a theorised chemical imbalance, are not the same thing. People often use alcohol and illicit drugs to change their brain chemistry. Although these drugs have the effect of dulling emotional pain or heightening positive emotions, I doubt that anyone would suggest they are correcting a chemical imbalance.

Unfortunately, many medications marketed as anti-psychotics have significant adverse effects, which reduce people's health, wellbeing, capacity for social engagement and life expectancy. These adverse effects include sedation and lethargy, weight gain, metabolic syndrome and early death (Moncrieff, 2015; Saha, Chant, & McGrath, 2007). Yet despite such serious side effects, these drugs are still routinely used as a first, and often only, treatment option for people given a diagnosis of a psychotic illness. Consequently, I would suggest that for many people it is the effects of medication, rather than their original presenting issues, that preclude them from gaining and sustaining employment.

In the issues paper, it is acknowledged that despite large amounts of money being invested in mental health, this seems to be having little effect in reducing the incidence of mental illness or improving the capacity for people with a mental illness to participate in society. I believe this provides a strong argument for the need for a paradigm shift away from the dominant medical model of mental illness. What we have been doing for the past few decades clearly isn't working. I believe services need to adopt new models such as the recently developed Power Threat Meaning (PTM) framework (Johnston et al., 2018). I believe that by beginning with the question, *what happened to you*, instead of the question, *what is wrong with you*, we will be in a much better position to help people who have been labelled with a psychiatric diagnosis to be able to move through the difficulties that have led them to be so-labelled and go on to contribute to society in valuable and meaningful ways.

Accessing Helpful Help

As a consumer of mental health services, I have had many experiences with psychologists in private practice that were not only unhelpful, but harmful. I believe this is due largely to the current poor training of psychologists. I understand that it is probably beyond the scope of this inquiry to explore this matter. However, I believe it is an important issue to identify.

Having completed a psychology degree, I know first-hand how little the training of psychologists prepares them for real-world practice. I believe there is an over-emphasis in both undergraduate and masters psychology degrees on how to conduct research, at the expense of learning the skills necessary to work effectively with clients, for example,

counselling skills. I believe it is absurd that undergraduate psychology students do not do any workplace placements during their 4-year degree.

Along with the difficulty of finding a highly skilled psychologist, consumers are confronted with the high cost of seeing a psychologist. The current system of subsidising only 10 sessions per year through Medicare is hopelessly inadequate for most people who need support with mental health issues. Only the very mildest of conditions can be meaningfully addressed in 10 sessions. This means that people with more complex needs are faced with large out-of-pocket expenses, which are often out of reach for those who most need the support. Consequently, many people who could potentially address their mental health issues and gain or re-gain employment are unable to do so due to the unaffordable cost of quality care.

I believe the current process of having to go to a GP to get a mental health plan in order to see a psychologist under Medicare is not cost effective. Rather, I believe the costs involved in having GPs act as gatekeepers could be better spent in providing more Medicare-funded sessions for people with severe and complex mental health issues.

Beyond Mental Health Services

Disability Employment Services (DES).

I applied for and was granted the disability support pension (DSP) in 2012. I then sought support from disability employment services (DES) because I desperately wanted to, in time, be back in employment and off the DSP. My experiences with the two DES providers I saw were not only unhelpful but highly distressing. This greatly exacerbated my mental health issues. I found that the DES staff I engaged with, lacked knowledge and expertise in working with people with mental health issues. For example, I had a meeting with one provider in a café. I became increasingly distressed during the meeting and the provider responded to this by telling me she was going to end the meeting if I didn't "settle down." I then proceeded to go into extreme crisis (i.e. crying, rocking and self-harming).

I ultimately managed to find myself employment with a women's support service that I was already linked in with. In order for the service to gain funding for employing me, we set up the arrangement through the DES provider. A few months after I started in the role, I had a crisis episode in the workplace. To illustrate the seriousness of this incident, a staff member who witnessed me in crisis was subsequently granted two weeks stress leave. On the day of the incident, I called my DES caseworker for support, only to be told that this was an issue for my psychologist to deal with. My psychologist in turn responded with confusion saying, *I thought it was their job to support you in employment.* Due to this incident, I was sacked

from that employment position. This experience was devastating for me. I had hoped that this role would be a first step towards me moving into more regular employment and thus off the DSP. Instead, it had the opposite effect. In that situation, I was already known to my employer, they knew I had an extensive trauma-related history and they identify as a trauma-informed service. However, the way in which they dealt with the crisis, both when it occurred and subsequently, highlighted to me the hopelessness of my situation. If they couldn't support me when in crisis, then I can see that it is unrealistic to expect an employer within the broader community to do so.

Based on my experiences, I do not believe the DES system is helpful in supporting people with mental health issues, into employment. Consequently, I do not think it is cost effective. Staff are poorly trained and seem to lack any real mechanisms for helping people gain employment. When I first engaged with them, I naively thought DES providers had a list of jobs available and that they matched job seekers with those jobs. However, I quickly learned that this is not the case. The providers I engaged with, seemed to be at a loss to know how to help me into employment. For example, one provider began by saying I needed to sit a literacy and numeracy test despite the fact I was completing an honours-level university degree at the time. From my perspective, the DES system is a very expensive and ineffective white elephant. Rather than funding these private service providers, I believe the government should channel money into providing:

- Publicly funded social workers who can work with clients to identify and address their barriers to employment. When I enquired at my local Centrelink office about seeing a social worker, I was told they did not have any social workers. From my perspective, this is absurd.
- Direct funding to clients for expenses related to education (e.g. costs of textbooks) and employment (e.g. cost of work clothes).

Conclusion

Thank you again for the opportunity to make a submission to this inquiry. I believe we are at a point where it is generally recognised that what we are currently doing in the mental health sector is not working. Consequently, I do not believe the answer is to simply pour more money into doing what we are already doing. Rather, I believe it is time for a paradigm shift in how we conceptualise mental illness.

References

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