

Submission to the Productivity Commission Enquiry into Mental Health

Australia's economy is deeply reliant on resources and infrastructure gained by inflicting trauma that caused intergenerational mental illness and on continuing to exploit people disadvantaged by past or present injustice. Current policies give low priority to removing known determinants of poor mental health for many Australians, while giving those who have benefitted from such injustice the best access to circumstances less likely to cause mental ill-health and the best access to mental health services.

We now know that mental health conditions arising from genetic inheritance or chemical deficiency, regarded as aberrant and treatable through drugs, are only a small fraction of the mental ill health conditions that affect Australian society. However, media representations and politicians' statements re-inforce these outdated concepts, as it is convenient and beneficial to them to individualise the mentally unwell, and have other Australians condemn the 'insane' (or sometimes 'evil') who harm others, pity unfortunate 'sufferers' of mental ill-health, voyeuristically glimpse the life of the 'other', and laud the exceptional sufferer who 'succeeds' in modern society despite their illness.

Humans are social animals. Most mental illness in this country is an outcome of our society's foundation on one or more of the following:

- the dispossession (of land, language, culture and primary industry resources¹) and horrific treatment of Indigenous Australians (including using them as slaves to build the foundations much of the economy, including rural railways, the pastoral industry, and by sending girls to be domestic servants), and the subsequent failure to more than trivially address the consequences;
- reliance of our economic model on the fragmentation of families and social groups, including convicts, slaves ('indentured workers') and immigrants brought here for economic reasons;
- gross inequity in wealth, income and access to work, a safe work and/or living environment and health services; and
- deliberate deception and exploitation of people who do not have the education, intellect, resident status and/or connections with powerful people to recognise or resist their exploitation.

Similarly, our governments pour considerable resources into detecting and punishing people who have used illegal substances, in accordance with a view that it is the substances that cause addiction and that punishment can enable these people to stop using them. However, the vast majority of illegal substance abuse occurs in response to poor mental health arising from current or past personal and/or inter-generational experience of trauma, poverty and deprivation of meaningful love and/or the means to improve one's circumstances.

The social determinants of mental and other ill health are well known and include poverty and lack of control over decisions affecting one's life. These are most starkly demonstrated in Australian Aboriginal communities (the recent report of the WA inquest into 13 child suicides says it all) and in the outcomes for people condemned to live indefinitely in Australia's offshore detention camps, where serious mental health has been the predictable outcome for almost every detained person and for many of those employed to run the detention system. Consequences of poverty include living in unsafe situations (which increases the likelihood of experiencing of trauma), exposure to pollutants known to impact mental health (by virtue of having substandard or no housing or working in unhealthy environments) and inability to access a healthy diet, education or adequate support services.

¹ Bruce Pascoe in *Dark Emu* has documented the substantial areas of agricultural crops and landscapes modified for harvesting wildlife that were appropriated by European 'settlers', denying those who had built these resources the opportunity to use them and feed their people, while affording the settlers ready-made feed and cleared and cultivated land.

In the case of Aboriginal people, successive Governments have repeatedly changed the policies, programs and rules affecting their lives, without meaningful prior consultation, let alone opportunity for self-determination. Every time a community initiative starts to prove effective in combatting social disfunction, its funding is terminated, the Aboriginal Council running it is dissolved or by other means the people trying to improve the circumstances of their community are prevented from doing so. This happens so frequently it is hard to believe it is not the implementation of a policy intended to destroy the will of Aboriginal people to keep trying to overcome past disadvantage and improve their circumstances. This process is clearly explained with numerous examples by former Liberal Federal Minister for Aboriginal Affairs Fred Chaney (<https://www.abc.net.au/radionational/programs/bigideas/fred-chaney-says-dysfunctional-policies-are-crushing-remote-comm/9959538>). Another example of making it impossible for Aboriginal people to improve their circumstances is governments defending the existence of alcohol outlets near communities that want to control the availability of alcohol and thereby its impact on their lives (<https://nacchocommunique.com/2019/03/13/naccho-aboriginal-health-and-alcohol-fareaustralia-overcoming-indigenous-familyviolence-download-new-study-from-marcialangton-unimelb-where-experts-find-success-in-alcohol-management-plans/>). Media and politicians blame problems arising from ready availability of cheap alcohol on the individuals who cannot limit their drinking or who behave destructively when drunk, rather than on those who target the vulnerable in order to make excessive profits.

The Government's cashless card policy, imposed allegedly to reduce alcohol consumption, further removes people's control of their lives and makes their lives much more difficult, was first imposed in Indigenous communities before being extended to disadvantaged mixed heritage communities. It has been directly linked to multiple suicides. It is a clear example of a policy that causes, rather than addresses, mental ill-health.

There is one category of mental health condition that the terms of reference do not readily address. People who suffer Narcissistic Personality Disorder (NPD) proliferate in politics, media and in senior management of corporations and government departments (but are also present throughout society). They generally have no insight into their illness, nor the massive consequences they cause for others as a result of their excessive sense of entitlement and ability. They do not respect normal boundaries of appropriate behaviour and personal space. The 'Me Too' phenomenon has highlighted some well known people with NPD. Commissioner Hayne made the point that some of the directors of financial institutions fail the 'proper' part of the 'fit and proper' test. Most of the extreme inequality that contributes to the poor mental health of so many people is driven by the desperation of NPD sufferers for 'narcissistic supply' to mollify their insatiable sense of self-entitlement.

Any enquiry into mental health must consider the real cost of policies that drive a particular economic and social model in preference to alternatives, and the opportunities to reduce the mental illness and other costs that result from perpetuating the current economic and social paradigm.

Bruce Alexander (Alexander, B.K. (2008). *The Globalization of Addiction: A study in poverty of the spirit*. Oxford, UK: Oxford University Press) has comprehensively debunked the concept of addiction as a moral or health flaw of the individual, and shown that its prevalence is a predictable product of the prevailing social and economic model. Healthy societies are almost addiction-free, dysfunctional, unfair societies cause mental illness and are wracked by high levels of addiction and attendant crime.

Personality disorders (including 'Borderline Personality Disorder', which is expressed with dire consequences in at least 4% of our population) arise if susceptible people had specific early life

experiences causing them as infants to discover their carers to be inconsistent. The behaviours of parents (and other adult ‘carers’) that trigger personality disorders include violence, neglect, unpredictability (including absence) and shaming. Crucial to the development of these conditions is that the child has no fundamental belief that anyone loves them unconditionally. NPD sufferers develop in similar circumstances, but often despite growing up with ample material resources, where their upbringing fails to appropriately require them to recognise and address the consequences of their actions.

Some countries, such as Scandinavian ones, recognise the significance of early child development and ensure that every family with a new child receives adequate support, time off work, resources, etc. Family health staff visit every family regularly to see how the community can better support and involve families as they deal with the hurdles of parenting and the ups and downs of work, unemployment, ill-health and, sometimes, bereavement. The Government provides basic necessities to every new child, effectively saying “this country and society loves and cares about you and will support your parents wherever possible to see that you are able to develop into a valued member of our society”.

Australia fails miserably at valuing its citizens, instead relying on voluntary organisations and threadbare State departments to spread meagre resources across far too many families. One in four children in NSW has been the subject of an adverse child welfare report. How can it have got this bad? Because of an ethos that channels money to those already well off, while blaming those born into struggling families for the way they grow up, then taking them from the only people who care (however badly) for them, and brutalising them in institutions run by people who are neither trained nor resourced to help them overcome their histories (see the report of the NT ‘Don Dale’ Royal Commission).

How can we expect people to not grow up angry at the world, feeling they owe nothing to a society that never showed it cared about them, etc., if we do not demonstrate our care? In consequence, sufferers parent another generation of ill-treated children, deliver fatal punches to innocent victims, and rely on self-medicating to drown the traumas of their childhood and current life.

At the other end, we are aghast at behaviour of people on very high incomes whose wanton criminality and disregard of their consequences for those subject to their decisions has been trawled over by the Banking Royal Commission and recent court cases. How can the elite-school-educated children of very senior public servants and politicians, who never went without their needs being met, grow up to feel so entitled as to defraud taxpayers and others so that, barely out of school and at the expense of their victims, they can have lavish lifestyles including multiple cars, boats, houses, etc? This is mental illness (undiagnosed because they have no insight into their condition) wreaking havoc on our country.

A major cost to our society and economy from failure to attend to nurturing good mental health and inadequately addressing poor mental health, is our law enforcement and prison systems. The vast majority of people in our prisons are there because of the poverty or otherwise impacted childhood. And yet mandatory sentencing laws, youth detention and prisons seldom do much to address the mental health problems of the people they capture. Rather, as we have seen in the NT Royal Commission example (but re-inforced around the country) these places are more likely to brutalise children and people so as to reduce their mental health and ensure they return to prison rather than assist them to overcome their disadvantages and contribute meaningfully to society. A small number of people are so damaged (psychopaths) that they cannot be safely rehabilitated outside prisons. Other than these, the only people who should go to prison are those who commit “white collar” crimes, because they are the only ones who have a choice and will actually change their behaviour because of the threat of jail.

The availability of mental health services is severely limited, underfunded and incapable of making a difference for more than a few people. Public mental health services are so constrained, that only people in crises can access them. When people are in crisis, they can't get much benefit from treatment. Once they are brought out of crisis and could start benefiting from ongoing treatment they are prioritised below the people now in crisis!

Many private mental health services are of very poor quality. There is no link between the mental health practitioners and the administration, so residents are treated by administrative staff in ways that can be severely contra-indicated for their condition. This includes sudden or frequent changes of room (for many PTSD sufferers this can recreate their trauma) or exposure to other triggering events, such as male residents abusing vulnerable female residents.

Treatments such as Dialectical Behavioural Therapy need to be delivered by practitioners with a sound understanding of Dr Lynehan's method and experience enabling them to comprehend the responses of personality disorder sufferers. This is why reputable practitioners deliver it in teams, which enable new practitioners to gain the requisite skills under the tutelage of experienced practitioners and to appreciate its nuances. Many day and resident DBT treatments are delivered by recent graduate psychologists who have none of the empathy or understanding needed to assist their class participants and receive no guidance or supervision. Further, DBT should be delivered in a group setting comprising participants with similar enough conditions that they learn from each other. Many private clinics deliver to random assortments of clients, degrading the benefits for those who most need help, but maximising the fees they can charge. Parents, government departments (e.g. Defence) and private health funds spend a fortune on such useless treatments as the residents have to repeatedly cycle through the clinic each time they reach crisis point, but without ever getting enough help to be able to improve long-term. Private, foreign companies are discovering how to make this very profitable by cutting every corner while taking advantage of people paying to send their loved ones for treatment in the belief that they will actually be helped. The number of truly effective DBT courses available in Australia could be counted on one hand.

The main thing the clinics do is to drug the residents to the eyeballs so they are easier to manage and then discharge them after a few weeks as they are no longer exhibiting the symptoms of their crisis. Inevitably they are soon back at crisis levels and are again admitted for 'help' (read 'to get them out of the way of their family').

ADHD is a condition where a class of drugs has been found to reduce symptoms and improve sufferers' ability to function in modern society and work. The Tasmanian Government has decided that bureaucrats can overrule the prescription decisions of treating psychiatrists. The Pharmacy Services Branch (PSB) of the Tasmanian Health Department applies an arbitrary ceiling on the number of prescriptions for certain medications, including Ritalin. As a consequence, long-term sufferers of ADHD who have been high-functioning by prescribed use of Ritalin, having moved from interstate to Tasmania, have found they cannot have any prescription for Ritalin filled until they a. have established a relationship with a treating Tasmanian psychiatrist (it can take many months just to get a first appointment, and then multiple appointments are necessary in order for the psychiatrist to be able to demonstrate a good knowledge of the client), b. subject the client to an unannounced urine sample which must be 'clean' of any other pharmaceutical or illegal substance; and c. submit an application to the PSB, and await a positive outcome. Even if the application is successful, it must be reviewed after three months and then again annually. Thus a person who is dependent of Ritalin to work or attend university will experience repeated hiatuses in their medication, leading to problems of medication withdrawal, inability to work or study, dropping out just before exams (due to the timing of the hiatus), etc. This has led people with ADHD to seek illegal drugs to cope,

making it harder to ever be approved for prescription. I have heard several accounts of suicides by people who despaired of ever being permitted to purchase the treatment prescribed for them by their psychiatrist. Because there is a small pool of psychiatrists in Tasmania, and the PSB can ban them from ever prescribing, there is strong pressure on psychiatrists to not submit too many applications, regardless of the number of clients they believe should benefit from the medication.