Submission to the Review of the National Mental Health and Suicide Prevention Agreement

Thank you for the opportunity to make a submission to this review of the National Mental Health and Suicide Prevention Agreement.

I make this submission as an individual consumer/patient/citizen. [redacted]

Thankfully, for most of my 43-years until 2020 I enjoyed good physical and mental health, except for a few 'normal' difficulties around grief, work and loss, common difficulties of military service and despite a childhood encounter with a paedophile. However, my mental health deteriorated in the national and personal circumstances of 2020, and despite working hard with a lot of help to recover, I am now considered 'totally and permanently incapacitated'. I am too young to retire, I still had a lot to contribute in the workforce, and I have used all the lifestyle measures to optimise recovery/mental health.

I have had access to many mental health resources that have been helpful at the time. However, I have observed several key gaps that waste mental health resources and compromise recovery:

* Women's mental health issues are sidelined from psychiatry, notably PMDD (even though it is a DSM-V diagnosis) and peri-menopause.
* The system is fragmented between public and private systems, and inpatient and outpatient care.
* This is particularly problematic for veterans, as DVA delays and denies access to recommended/prescribed treatments; but the theoretical access to private/DVA resources activates public system policies that exclude veterans from public care. (Except in a crisis, but it is a waste of life and medical resources to be pushing patients into cycles of crisis and respite, rather than enable reasonably timely access to outpatient treatments.)
* Wasted resources - referring round in circles.
* Infighting within the psychiatrist profession about the 'evidence base' of new treatments such as ketamine and psychedelic assisted therapies. (This has been too hard for me to express, but I would appreciate the opportunity to be heard if possible, or that you listen to difficulties other patients have had in accessing these treatments in a timely enough manner. I know they're new, but when you are in a situation like severe PTSD 'just wait a couple of years while we make a policy' is impossible, as is navigating between providers who are prohibited from talking plainly on their websites about their approaches to these treatments.)
* I have unfortunately required three assessments for workcover/superannuation claims. Although the psychiatrists are engaged as 'independent' medical experts, in practice they are adversarial and biased against the claimant. Even in situations where you are committed to honesty and have a career of decades in work environments that require the highest standards of integrity, they treat you like a liar and a criminal. Especially given the discontinuities and gaps in private and public systems of care, this is extremely destructive. [redacted].
* When practitioners breach expected standards (code of conduct or Charter of Healthcare Rights), AHPRA and other agencies tasked with responding to complaints too slow and give no accountability to the patients who have been wronged.

This has been very difficult to write and edit, even though I used to be good at professional writing. I am sorry I could not make my comments/experiences fit your form for consumer feedback. I have tried to add the summary above and hope you can see the context/details in the longer sections below. Where possible, I have highlighted in bold my requests for actions for you to consider.

I request that you publish the body of this submission under 'Monica M' rather than my full name. Although the most sensitive details are in the confidential attachments, it is embarrassing to me that I cannot express my requests more coherently despite by educational and professional background, and despite the time and effort I have put into this submission.

Do you feel that mental health/suicide prevention services have met your needs?

- Most of the services have met most of my needs in the short term. My psychologist has identified three main reasons for hospitalisation - immediate safety, medication change and respite - I have needed all three at times. I have used the help of ACT emergency departments, the (public) Mental Health Short Stay Unit, Acacia ward, Hyson Green, Deakin Private Hospital and the Cabrini womens mental health ward (in Melbourne). Thankfully, I have never needed to be admitted to the Adult Mental Health Unit, which has a bad reputation for violence, noise and distress, though each time I have needed to go to the ED I have been in a headspace that I don't even care if I have to go there. I have had some help from the 'Wayback' peer support service and some efforts at help from Open Arms. Thankfully, I have had long-term support from my GP and psychologist. I want to recognise the hard work, skill, sensitivity and compassion of many people who provide mental health services.
  - I have used public short stay and mental health wards; two different private hospitals in Canberra and one women's mental health hospital in Melbourne.
    - Short stay unit, when I have needed urgent care to help deal with overwhelming suicidal/self harm urges or feelings.
    - Often I can and do manage these feelings at home or with the help of my psychologist. But it has been impossible to get long-term 'remission' of those feelings, and enduring the intensity is too hard.
  - When I have needed help with strong and graphic suicidal thoughts, the suicide callback line has been worse than useless. Unlike lifeline or other helplines, they start out with insensitive demographic/bureaucratic questions before they even start to listen to what is distressing. Eg 'do you have a disability' when I have no physical disability but am in the middle of a drawn out process of assessing mental impairment; 'are you Aboriginal or Torres Strait Islander' when I am not but my family is, so there are relevant and difficult stolen generation issues at play.
  - Lifeline has been helpful on about 10 occasions. Sometimes they're not, but thankfully one sensitive call taker explained that well and suggested I can hang up and call back if I need to. But a couple of times it has been devastating that they had very long (50+ minutes) call wait times coinciding with periods when self harm and suicidal ideation have been really distressing for me. I find it really upsetting that so much of the publicly and privately funded mental health support system relies on this volunteer service to help people who 'fall through the gaps'; it is worse that so many government, media and private organisations raise distressing content in recklessly unbalanced ways and refer people to Lifeline to pick up the pieces. Eg reporting/responses about the Royal Commission into Institutional Abuse; every media article since 'MeToo' about sexual assault, especially the horrific failings of the justice (and political) systems around the situation of Brittney Higgins and Bruce Lehrman.
    - I don't want more 'trigger warnings' that exclude me from accessing media like the responsible citizen that I am; I want responsible and accountable political, media and justice systems that slow down the reporting cycle enough to provide careful and constructive responses, not a barrage of upsetting and sensationalist 'awareness raising' details and no (or glacial and fragmented) progress on justice or institutional responses.
  - My local pharmacist has been a quiet helper in this journey, especially when he has altered dispensing or looked after dangerous amounts of medications at times (eg during antidepressant changes/when my partner has been away) when temptation of overdose has been a problem. He has been reliable, respectful and discreet; exercised good judgment without seeming judgmental or patronising. I hate the commercial corruption of pharmaceutical industry at the highest levels, but my local pharmacist has been invaluable. In this role, he has better met the standards and ideals of his profession than key psychiatrists have.

Key gap - Women's mental health issues are sidelined from psychiatry, notably PMDD and peri-menopause.

- At a recent admission to Cabrini womens (mental health) hospital in Melbourne, the psychiatrist impressed on me on day one that 'peri-menopause affects the brain first', and that she thinks that this has been a substantial cause of my severe mental illness symptoms since 2020, before any physical symptoms were apparent, despite careful observation.
    - That doctor, [redacted], is a psychiatrist who has correctly identified that **competence with dealing with women's hormonal contributors to mental illness needs to be integrated within psychiatric practice**, not primarily palmed off/referred to other specialists or back to 'specialist' (women) general practitioners. **This is more sensitive, practical, effective and efficient, and I hope the Productivity Commission will recommend that the RANZCP and others promote that model of competent practice**.
        - Hormone therapy commenced on that admission helped significantly but not entirely, I'm still badly affected by cPTSD, depression and probably PMDD. Another Telehealth GP that specialises in peri-menopausal health had previously recommended that it was too early in perimenopause to try hormone therapy. A year later I tried it anyway after an 'independent medical expert' said that without trying hormone therapy I couldn't be considered eligible for superannuation entitlements (ask me if you want more info on the logic to that). I had some support from my GP, but by that stage the private psychiatrist had discontinued my care, and the stress and other factors around that made that trial of hormone therapy a mess.
        - It is a shame on the psychiatrists of the ACT that I had to travel interstate to access care that integrates 'women's health'. I respect the difficulties that face the public health system, but the problem here is an attitude among psychiatrists (male and female) that women's health/hormonal problems is not their problem.
    - I have sought help with PMDD symptoms from about 12 of the psychiatrists. None have yet given clear answers about it except the one who was at least transparent enough to say that he wasn't able to deal with it on that admission and that differentiation from progesterone intolerance would be 'trial and error'.
        - Each of my overdoses have been while premenstrual, though it took a couple of years for me to notice that pattern.
        - I understand it may be caused exacerbated by trauma, stress and perimenopause; that it is hard to differentiate from progesterone intolerance.
    - The RANZCP needs to catch up with observations of that last ten years or so that women's health has been systemically excluded from scientific research and medical practice. 'Adult general psychiatry' is treated as gender neutral (aside from issues of gender dysphoria/ gender 'affirming' therapies), but in practice this ignores mental illness arising from women's normal and abnormal hormonal variations. They need to find ways of ensuring that all psychiatrists are competent with dealing with normal life stages like puberty and menopause. If this is too much for 'general adult psychiatry' to cover, RANZCP should identify a sub specialisation of perimenopausal mental health and exercise professional leadership to ensure an adequate number of practitioners, and prompt, respectful and adequate referral.
        - On the RANZCP's 'Find a Psychiatrist' webpage, it is possible to search for a psychiatrist by any DSM condition (and other filters) except PMDD. When I noticed this gap I contacted the RANZCP, the policy officer seemed to acknowledge that problem and said they'd consider adding that condition, but no change has occurred. He distanced himself from the issue, saying that it is up to individual psychiatrists to identify their areas of practice and decide whether or not to list on Find a Psychiatrist, but how else are patients (and GPs) supposed to find current and accurate information? This needs professional leadership from RANZCP.
    - I acknowledge distinct difficulties that men face with accessing mental health support. But two wrongs don't make a right, and these shouldn't be competing resource/awareness issues but a sensible attitude of professionals to be competent in relation to men *and*

women. Psychiatry is not a standalone profession of neck-up medicine, but is a specialisation of doctors who are supposed to understand the whole body: men and women. (I do understand why geriatric and adolescent psychiatry are subspecialisations). It's inexcusable in principle and a waste of resources that psychiatrists avoid aspects of mental illness caused by 'lady problems'.

System fragmentation - especially affects veterans

- Veterans - outsourced to private 'system', but the psychiatry practices operate as business and when difficulties arise, prioritise those business and practitioner comfort issues over accepted standards of patient care.
- DVA - despite the Royal Commission, they still delay access to care.
  - In November 2023 my psychiatrist recommended I seek access to MDMA assisted therapy. I have 'successfully' gone through several providers' (painful) screening processes, but DVA simply keeps delaying its approval of funds. This stuffs around patients, who are already at their wits end when they are prescribed this treatment. It also stuffs around providers, who DVA expects to administer the programs and liaise with patients; requires more paperwork and pays them less fee than the fair market rate. I expect this is also a source of moral injury for people in this high turnover bureaucratic system, watching despairing people be told to wait indefinitely despite the existing entitlement to recommended treatment.

Telehealth and internet support

- I appreciate that telehealth and internet support is enabling some access in a way that helps some people, especially people in rural areas or with caring responsibilities or limited mobility.
- But I find telehealth ineffective; it doesn't feel safe or real. Some practitioners acknowledge that there's no substitute for real face-to-face communication, especially when discussing trauma etc. But it seems that practitioners are using the potential availability of telehealth as an excuse to decline referrals.
- CBT is 'evidence based' for certain purposes, but there are recognised limitations of that therapy. Yet it is being pushed and funded as a band-aid panacea for simpler issues, at the expense of access to care for people with more complex mental illness.
- I do appreciate that the government is funding Sane. But the anonymity requirements of that forum are at the expense of a sense of community and real connection. This exacerbates rather than mitigates a feeling of isolation.

Key gap - continuity of care

- The lack of continuity of care is a key problem. Especially among privately psychiatrists, which is particularly a problem for veterans.
  - It is recognised that repeatedly answering questions about trauma is retraumatising, yet this is necessary to some extent each time you meet a new psychiatrist, and so required by the public, private and veterans systems for reasons that are avoidable at little cost.
  - I have had to see over 25 different psychiatrists (including three GPs filling psychiatrists' roles) in less than five years. [redacted]
    - Most were compassionate and technically thoughtful individuals.
    - I understand that *some* discontinuities are inevitable, between inpatient and outpatient services, and between the public and private systems.
    - The most painful let-downs have been from two private psychiatrists who have discontinued seeing me, for unfair reasons; without complying with their basic obligations/patient rights; and refusing to resolve the issues.
- As well as addressing fragmentation within the public system, and between public and private care, I ask you to **recommend that RANZCP promptly develop and display professional leadership to build a culture of not dismissing patients**. The systems for redress are too difficult to access even in the best of mental health difficulties; proactive leadership is required to help practitioners deal with patients in extreme distress without excluding them from care.

Have you ever been unable to find a service or use a service you needed?

Yes.

- I have been turned away from ED when I was in despair and sought help, following previous recommendations to go to the ED if I felt like that.
- I have been dismissed by two private psychiatrists, for unfair reasons in the context of my illnesses and their failures to communicate and meet other standards.
- I have been denied referrals to other psychiatrists. If I'm 'lucky' and the appointment scheduled for next week goes ahead, it will have been 13 months since a scheduled outpatient appointment, despite three hospital admissions and recommendations for follow-up care.
- The ACT Minister for Mental Health is completely inaccessible for communication about her role. Written responses take months and simply refuse to address the questions clearly asked. Correspondence and subsequent MP questions on notice that shows this can be provided on request.

When I first became unwell in late 2020, the doctor who treated me said in my return to work recommendation I had really good prospects for recovery. Four years later, I'm considered 'totally and permanently incapacitated', mostly as a result of fragmented psychiatric care that has failed to address the hormonal elements of my normal life stage, and has often been the opposite of 'trauma informed'. I recognise my financial, educational, social and physical privilege and want you to recognise that I have done every 'lifestyle measure' possible - eat well, exercise, don't drink or smoke or do recreational drugs, maintain social connections and purposeful activity, work hard through psychotherapy. Sure there have been the difficulties of childhood and military abuse and discrimination, but if someone in even the luckiest situation can't access reliable health care, your system needs to be better led and managed.

I have been sad to see that the National Mental Health and Suicide Prevention Agreement aims to 'work together to build a people-centred mental health and suicide prevention system for all Australians, with lived experience of mental ill health and/or suicide embedded in the design, planning, delivery and evaluation of services.' I am sad because I have seen so much of the opposite of that, despite dedication and personal efforts of many good people. I hope your review will address some of the gaps identified by me and others.

Yours sincerely,

Monica M

26 March 2025