Submission
No 141

INQUIRY INTO EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES

Name:	Michael Strutt
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About the author

My name is Michael Strutt. I have been an activist in the areas of criminal justice, mental health, prisons and policing since the 1990s, with a hiatus from 2004 to 2013 to attend to my own mental and physical health problems. Most of my activist work has been with Justice Action and the Indigenous Social Justice Association, with an emphasis on forensic science (especially forensic DNA), deaths in custody, drug addiction (both illegal and prescribed), blood-borne communicable diseases, sex offending, restorative justice and offender treatment and rehabilitation programs.

My educational background is primarily in science and mathematics. My professional experience has mostly been as an IT contractor. For the past fifteen years I've been a disability pensioner.

I am a proud Cabrogal man.

This submission is my own work and should not be seen as representing the views or policies of Justice Action or the Indigenous Social Justice Association.

My mental health journey.

Along with everyone else, over my life I've faced my share of physical, social, emotional, psychological and existential challenges. As with an increasing proportion of us, some of my struggles have earned me a range of mental health diagnoses, starting with a self-diagnosis of what was then called manic depression while I was a teenager studying psychology at Newcastle University. That would be officially confirmed by a clinical psychiatrist almost 20 years later as 'bipolar disorder with psychotic features'. Along the way I've also been officially labelled with Asperger's Syndrome, PTSD and major depression.

Overall I've not found these diagnoses helpful, though I must admit I'm kinda proud to identify as Aspie. An exception was when my GP told me I had PTSD a couple of years after I'd been trapped in a fuel-soaked car wreck. I believe the book and stack of photocopied journal articles on desensitisation he gave me helped overcome my crippling responses to the smell of petrol and hot motor oil. But by and large, putting a name to my distress told me next to nothing about its causes, likely progress or potential treatments. It did however lead to stigmatisation; not least by mental health professionals.

By seeing me through the prism of a checklist of symptoms rather than considering my life circumstances the question became "What's wrong with you?" rather than "What's happened to you?". Instead of addressing my often stressful and unhealthy situations – exacerbated by a suite of autoimmune disorders largely associated with the HLA-B27 antigen I carry – medicos wanted to alter my 'defective' brain chemicals or thought patterns. Instead of acknowledging me as a unique, complex, thinking, feeling individual I was being trimmed to fit the straitjackets sewn for me from patterns in the Diagnostic and Statistical Manual of Mental Disorders (DSM).

I was being told my disorders were my thoughts, feelings, outlooks and perceptions.
That the disease was me.

Worst of all, the stigma that comes with mental health labels has the force of law. Once I'd been deemed mentally ill it became legally acceptable to abolish my right to bodily autonomy and detain, restrain and drug me against my will, despite having committed no crime. That often prevented me from seeking professional help for my distress or speaking frankly about it with friends, family and colleagues. In particular it isolated me with the severe suicidality I'd suffered since adolescence, which I knew was a trigger that could result in the removal of my most fundamental human rights. It became a closely guarded secret from my doctors and all but a handful of my most trusted friends.

So I've found the mental health system to be of little use. Its ideology and attitudes foster the stigma which underlies much of the suffering associated with a mental disorder diagnosis. Its therapies can be ineffective, abusive or even dangerous and attempting to access ones that may be helpful can make you vulnerable to having harmful ones imposed upon you. And it insists on locating the problem within the individual seeking help, rarely if ever trying to alleviate the occupational, social or personal stressors known to be closely correlated with psychological dysfunction.

But this story has a happy ending.

Over my lifetime I've found many ways to relieve my emotional suffering. Some turned out to be ill-advised, such as self-medicating with illegal drugs. Some seem to have helped, such as attending to a healthy diet and exercise even when it seemed pointless, futile and difficult to maintain. Other measures have definitely benefited me.

When I finally came to terms with how the Australian employment environment and I had drifted irreconcilably apart and applied for the disability pension it freed me from trying to crush myself into what the late anthropologist Dave Graeber called 'bullshit jobs' to pursue the mostly unpaid work that was meaningful to me. By refusing to accept the paradigm that my mental health – or even my social identity – was dependent on regular paid employment I stopped being a corporate misfit and became a contributor to the society I wanted to see.

What has made the most difference is coming to accept everything I am, rather than alienating aspects of myself as a 'disease', 'disorder' or 'weakness' attacking me from without. The spontaneous altered states conventional psychiatry calls 'psychotic episodes' have become valued experiences as I've learned to anticipate their onset and (usually) ensure I'm in a safe, reassuring environment when they occur. I've even acquired a small degree of control over them, sometimes able to delay them when they're inconvenient or bring them on when I'm prepared. I attribute most of these skills to the *vipassana* and *anapanasati* practices I picked up during my years in South and South-East Asia. It was also my sojourns in other cultures which taught me alternatives to the conventional Western means of locating myself within my community and the universe as a whole.

My existential anguish came to a head in 2003/04 following a series of mostly unexpected deaths of people who had been close to me, including several family members ranging from my 82 year old grandfather being hit by a car to my 4 year old nephew drowning in a backyard pool. Instead of slowly healing the grief got worse and worse, causing me to withdraw from my voluntary work and social activities and subsuming the mood and energy swings I'd partially adapted to into paralysing unipolar depression that plunged me into a day-by-day, hour-by-hour struggle with suicidality lasting more than nine years.

It was my friend and colleague – and one of the great wise women who have contributed so much to my life – the human rights lawyer Moira Rayner, who told me I was undergoing a spiritual crisis; a *'dark night of the soul'*. I could concede she might be right but knowing that didn't help. I couldn't even meditate anymore. This was going to kill me.

But in October 2012 I found myself getting angry at a misleading and manipulative piece of science journalism I was reading. This was the first 'energetic' emotion I'd experienced in almost a decade. Within a few days my hypomania had returned and with it the anticipation of a psychotic break. I found I could not only meditate again, but focus my mind wonderfully while doing so. Finally, in the midst of writing an email of birthday greetings to my uncle, it happened. An ecstatic psychotic episode – or spiritual experience – that was to last five days. Shortly into it my entire world changed. Whereas previously my understanding of certain esoteric Hindu and Buddhist philosophical concepts had been academic – a form of intellectual adornment – I suddenly *realised* them. They stopped being something I knew and became something I *am*.

That single moment perfected my entire life, imbuing everything leading to and from it with clarity and wholeness. All the joy, all the suffering, all the successes, all the failures, the sceptical rationality and the lurid insanity; it all led both to and from that instant of profound lucidity.

There is no 'should', there only 'is'. It all fits together seamlessly and what I think of as 'me' is one with that continuum.

At that instant my suicidality and existential despair fell away and have never returned. I'd stopped struggling against the universe and my own being as something separate from it. I still have the energy fluctuations associated with bipolar disorder. I still get happy, I still get sad, but they're now flavours of existence not causes for concern. I still tick most of the same DSM boxes that earned me my psychiatric labels. In fact it may be worse now, as my acceptance of it probably means I 'lack insight into my condition'. But from my subjective perspective – which may be rejected by 'objective' mind sciences – life is sweet. In fact it's perfect.

I have my doubts whether someone who tries to drug difficult aspects of his mind into submission and obedience – whether voluntarily or otherwise – could have made such a complete recovery.

“Equity, accessibility and appropriate delivery of outpatient and community mental health care”

The word ‘appropriate’ is doing a lot of heavy lifting here.

Is it ever appropriate to inflict medical treatment upon someone against her will?

That question exercised a lot of minds in recent public debates about medically assisted suicide in the context of widespread conviction substantial numbers of people weren’t having their expressed desires to decline potentially life extending treatment respected. Yet for some reason it’s less often asked with regards to mental health treatments, though they’re often debilitating, of dubious therapeutic value and can carry significant risk of very serious side effects. Instead the matter is typically left to the experts.

One such expert is Dr Dainius Pūras, professor of child and adolescent psychiatry and public mental health at Vilnius University and former UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health.

As both an academic and practising clinical psychiatrist, Dr Pūras is exquisitely aware of the history of harmful mental health interventions and the limitations of contemporary ones. As a citizen of a former Soviet republic he also has considerable insight into the human rights abuses which so often result when political and legal authorities turn to pliant mental health professionals to enable medicalised oppression, authoritarianism, torture and genocide.

Dr Pūras has no truck with the biopsychiatric paradigm that mental disorders are best explained or addressed in terms of neurotransmitters or brain physiology. He feels the increasing medicalisation of human distress – particularly that of children and adolescents – is corrosive of public mental health and needs to be abandoned in favour of a human rights based response. He is also scathing of the suggestion coercive mental health care – which he says is rising worldwide – is medically or legally justifiable. He claims it puts governments across the world in breach of their obligations under the Convention on the Rights of Persons with Disabilities (CRPD).

Pūras’s reports, studies, articles and speeches are incisive, intelligent, compassionate, humane and eminently well-informed. I highly recommend them to the committee and hope it will accept both his 2020 report to the UN Human Rights Council and the WHO course guide ‘*Freedom from violence, coercion and abuse*’ to which he contributed as appendices to my submission. I have little to say about coercive mental health care that’s not already comprehensively covered in these two documents.

But to avoid imposing a tl;dr obligation on committee members with such substantial reports I recommend the more concise summaries of his position found in the World Psychiatry article he co-authored with Dr Piers Gooding of Melbourne Law School, ‘*Mental Health and Human Rights in the 21st Century*’ and the Epidemiology and Psychiatric Sciences study he undertook in conjunction with S P Sashidharan of Glasgow University’s Institute of Health and Wellbeing and Dr Roberto Mezzina, the Italian psychiatrist widely credited with establishing the world’s best practice mental health system in Trieste, ‘*Reducing coercion in mental healthcare*’.

Is it appropriate to offer someone mental health care without properly informing them of potential risks and benefits?

Or more to the point, is it appropriate to *misinform* them about the safety and efficacy of proposed treatments?

I attended my first biopsychiatry lecture while in my early teens when a family friend who taught at Sydney University took me on a tour of his workplace. The lecturer explained the hypothesis that schizophrenia is caused by an overload of signals along the mesolimbic dopamine pathways linking the ("emotional") limbic system with the ("rational") prefrontal cortex via the ventral tegmental area. He was frank in admitting there was no solid evidence for the hypothesis and it had been reverse engineered from the supposed effects of first generation neuroleptics such as chlorpromazine, which were believed to block the D2 receptor sites constituting the pathways. They act as a titrated, partly reversible chemical lobotomy.

By the time I was formally studying psychology the monoamine – or chemical imbalance – hypotheses of mental illnesses still had legs, most famously the one positing depression was caused either by a deficit of serotonin availability across neural synapses or a loss of serotonin receptor activity. This theory too was derived from the supposed mechanisms of antidepressant drugs – primarily monoamine oxidase inhibitors (MAOIs) - and would soon lead to the first selective serotonin reuptake inhibiting (SSRI) antidepressant blockbuster, fluoxetine (Prozac). But beyond a few ambiguous and contested autopsy studies of suicide victims there was still no physical evidence that might support of refute it. In fact, despite billions of dollars of funding, millions of hours of research, over half a century of concerted effort and regular, quickly refuted announcements to the contrary there are still *no* biomarkers or physiological correlates that can reliably confirm or deny the existence of any major mental illness. They're diagnosed on symptoms alone, with diagnostic criteria changing with every new edition of the DSM.

By the early 2000s independent psychiatric researchers had largely abandoned chemical imbalance hypotheses of mental illness amid a blizzard of inconsistent and contradictory findings, though some drug company funded research was still trying to adduce evidence for them as recently as five years ago. The final nail in the serotonin hypothesis coffin may have been driven by last year's meta-analysis of the evidence by Joanna Moncrieff et al, though it has provoked a vigorous backlash from sections of the psychiatric community, with some insisting there *is* evidential support for the hypothesis and others insisting the psychiatric profession had never believed or promoted it in the first place, blaming widespread misconceptions on pharmaceutical marketing campaigns and ill-informed GPs.

Nonetheless, many people prescribed antidepressants are still offered a dumbed-down version of the serotonin hypothesis as if it's an established scientific fact, though it's never even attained the status of a viable formal theory. What they aren't generally told is there is little evidence SSRI/SNRI antidepressants are significantly more effective than placebos, they can have life altering side-effects which don't always subside with discontinuation, there is considerable evidence linking them with increased suicidality and violence, particularly in young people, and they can be very difficult to withdraw from, especially as expert assistance in coming off psychiatric medication is almost impossible to find.

Antidepressant advocates say the most serious drawbacks of the pills can be largely obviated by carefully monitoring for warning signs and either changing the dose, switching to a different medication or adding more drugs to the mix to deal with side-effects, but that's not how they're generally administered in Australia; which has the second highest per capita consumption of antidepressants in the world after Iceland. Rather they're most often prescribed in quick consultations by busy GPs – who get much of their education about them from pharmaceutical reps – at the first indications of stress, sadness, anxiety or the drug company mongered affliction of 'social anxiety disorder'. Follow up generally ranges from cursory to non-existent unless the patient complains they're not working or causing side-effects. In my personal experience GPs can be reluctant to concede something they've prescribed is causing side-effects even when confronted with symptoms matching those on the medication insert.

From the early 2000s Australian prescribers have increasingly relied on the PHQ-9 and GAD-7 patient questionnaires to evaluate depression and anxiety. They are quick, easy to understand and produce clear, consistent results that can be used to indicate whether treatment is advisable.

The accuracy of PHQ-9 for depression has been estimated at 88% sensitivity (true detection rate) and 85% specificity (avoidance of false positives) which is below that of most pathology tests for physical diseases (e.g. the sensitivity and specificity of HIV tests exceed 99%). As the estimated prevalence of depression in Australia is 9.3% this means PHQ-9 could be expected to result in a false negative rate of about 12% and a false positive rate of about 60% were it to be administered to everyone in the country (i.e. less than 1 in 10 taking the test would actually have depression but more than 1 in 10 would be mistakenly assessed as having it).

PHQ-9 and GAD-7 have been praised for their ease of use even by those with little training in diagnosing mental illness (they were designed to be self-administered) but criticised as a threat to personalised medicine and doctor-patient relationships and for the low threshold at which they recommend treatment. For example, answering PHQ-9 questions that over the past two weeks you've experienced disturbed sleep, poor appetite and low energy on most days is sufficient to indicate treatment for depression, which in Australian GP surgeries will usually mean a prescription for antidepressants. Few doctors or patients are aware both tests were developed by Pfizer Pharmaceuticals, makers of Zoloft and Effexor; the former having become Australia's most commonly prescribed drug for anxiety and depression since the introduction of PHQ-9 and GAD-7.

While it's arguable ill-considered antidepressant prescription is the bigger problem due to the sheer quantity of them consumed by Australians their risks pale in comparison to those posed by the neuroleptic drugs marketed as "antipsychotics".

Setting aside their deadly but uncommon adverse effect of neuroleptic malignant syndrome, how many would voluntarily take antipsychotics if they knew the high risks of extrapyramidal effects, some of which are irreversible, with the most serious becoming more likely the longer you take the drugs. Or if they knew long term use of antipsychotics causes loss of brain tissue – particularly in the frontal lobe – and is associated with worsening negative symptoms of schizophrenia, functional impairment and permanent cognitive decline. Or if they were told a substantial and growing body of research indicates psychosis sufferers on antipsychotics for more than a few years are less likely to have recovered, more likely to relapse, more likely to be hospitalised and have poorer social and economic engagement than those who came off the drugs early or never started them. The results hold even when controlling for initial severity of symptoms.

Many well informed commentators such as Ben Goldacre and Robert Whitaker have long argued pharmaceutical companies have used their marketing and lobbying power alongside selective and misleading presentation of research data to systematically distort the perceptions of both the public and the medical professions as to the safety and efficacy of medications, especially psychiatric ones, and thereby compromise the very foundations of evidence-based medicine. I'm in no way qualified to confirm or refute their conclusions, but find the body of evidence they present to be both impressive and unsettling.

How can this be addressed? I haven't got a clue. The problem seems multidimensional and deeply rooted in our economic systems and professional and political cultures.

In 2005 the UK House of Commons Health Committee tabled its report *The Influence of the Pharmaceutical Industry*, a damning account of how drug companies were compromising UK public health by aggressively and misleadingly advertising their products to prescribers, influencing medical opinion leaders with significant direct payments and research grants, bankrolling NGOs and astroturfing 'patient groups' to promote 'better access' to their on-patent and often inferior, cost-ineffective or insufficiently tested medicines, neutering regulatory bodies with heavily resourced political lobbying and via a revolving door between the industry and agencies meant to oversee it and contributing to the over-medicalisation of the human condition and the 'pill for every ill' philosophy of engaging with it. Unfortunately the committee's findings and recommendations are largely out of step with the still dominant neoliberal economic ideology of promoting industry deregulation and prioritising 'productivity' over maintaining effective social services and remain essentially ignored by policymakers to this day.

At the very least I think the precautionary principle should be applied rigorously to all psychiatric drug administration – especially over the long term, for which there is a paucity of good quality research – and sceptical critical thinking brought to bear on all claims – both positive and negative – for their safety and efficacy.

Simply leaving it to the 'experts' just isn't good enough and it's vital the experiences of people who take such medications be honoured, their decisions on whether to continue taking them be respected and as much support as possible be offered to enable them to continue, discontinue or alter their drug regimen with a minimum of danger or adverse effects. They're the ones who will have to live (or die) with the consequences of the drugs they do or don't take, not the prescribers, not the regulators and not the marketers. It is they who are ultimately and inescapably responsible for their decisions in this regard and we should be doing everything possible to inform and assist them, not to over-rule them.

It's very easy to be prescribed psychiatric drugs in Australia – whether you want them or not. But it's almost impossible to find help coming off them. The outcomes for poorly managed psychiatric drug withdrawal range from mild to severe to fatal. This is a gap in NSW health care that desperately needs filling.

As long as it's much easier to start psychiatric drugs than to stop them the number of people taking them long term will continue to climb and the cost to our medical systems – both in providing the pills and dealing with their negative effects – will continue to mount.

Following many years of vigorous advocacy – not least by the All Party Parliamentary Group for Prescribed Drug Dependence – there recently looked to be some movement in the UK towards providing helplines and public clinics to assist people trying to discontinue addictive, psychoactive prescribed medication. Sadly it may have been a false dawn, with the NHS recently closing the only antidepressant withdrawal helpline in the country. It's to be hoped the NSW health system can do much better than that; and soon.

Is it appropriate to locate emotional and psychological suffering almost entirely within the sufferer while largely ignoring the social and environmental stresses contributing to it?

Given the problems with psychiatric medications it's fortunate the NSW government is well placed to improve access to effective community mental health care without recourse to medicalisation of any kind. What's more, much of it is the best sort of mental health care. The preventative sort that stops emotional and psychological suffering before it starts.

I'm speaking of the 'social' part of the 'biopsychosocial' mental health model that's given so much lip service but so little substantial support.

The neo-Kraepelinian biopsychiatric framework that has dominated the field since the decline of psychoanalysis in the 1960s and 70s is naive and incoherent. To claim the brain is the best locus for understanding and intervening in the mind makes as much sense as saying the best way to use Windows is to fiddle with the hardware of computers running it.

Human beings are social animals and our minds are deeply interwoven with our environment, cultures, societies, economies and personal histories. The long and expensive search for biological correlates of mental illness has been notable primarily for its lack of success, but we've long understood the contribution to poor mental health of poverty, discrimination, adverse childhood experiences, insecure housing and employment, physical, emotional and sexual abuse, bullying, lack of freedom and personal autonomy, poor diet, substance abuse, lack of fresh air, exercise, leisure activities and social connections as well as other environmental and social factors.

Yet when someone becomes unable to cope the default assumption is there's something wrong with *them* as individuals rather than with the complex network of events and relationships which make them who they are.

Minds don't get broken and they don't need to be fixed. They need to be nurtured so they can grow the capacity to adapt and contribute to the world they find themselves in. Sadly our society currently seems more focused on driving them to compete with each other to make ever greater contributions to our increasingly dysfunctional economy, even as it devours the ecological and social environments our minds depend upon for good health and survival.

There's one initiative falling squarely within the domain of the NSW government that would lead to a significant improvement of mental health across the state over time. ***Reduce the prison population.***

Our prisons are not only criminogenic – i.e. they *increase* crime – they're also major incubators for physical and mental ill health which is all too often spread to the wider community via the steady stream of people sent through them.

Most prisoners are sentenced to less than a year. Long enough to lose their jobs, housing, personal relationships, social standing and self-respect, but not long enough to benefit from the mostly ineffective or counterproductive prison programs that are supposed to 'uplift' them into becoming better citizens and nicer people.

By replacing much of our carceral, retributive criminal justice system with a community based restorative justice system we could save money, cut crime, repair some of the damage it does, reduce the physical and mental health burden on our society and offer greater healing to the victims, the perpetrators and the communities they share.

There will always be some people who need to be kept away from society – at least for a time – to attempt to ensure their own safety and that of others. But they're a tiny fraction of the 12,000+ people we currently have locked in NSW penal institutions. Nearly all convicted criminals will eventually return to the broader community. We're not preparing them or ourselves for that by warehousing them in an unnatural and dysfunctional social environment with a bunch of other poorly adapted people.

And for crying out loud, we need to stop incarcerating so many Aboriginal kids! Aren't they disadvantaged enough as it is? To talk about giving Aboriginal communities 'better access to mental health care' while sending them a steady supply of institutionally damaged young people is a joke.

In the second half of the 20th century we commenced a well-intentioned mental health initiative meant to get people out of the asylums and into the community where they could take their places as citizens and members of human society. But the community investment required to make it work never happened, so 'deinstitutionalisation' became 'transinstitutionalisation' and many of them were dumped into the prison system instead. We need to complete the process we started and make a place for everyone in NSW that isn't surrounded by razor tape and watchtowers.

I'm not pretending it will be simple or easy, but it has to be done for so many reasons. It's way past time we rolled up our sleeves and got down to it.

Of course there's many other things that can and should be done to improve the mental health of all people of NSW, not just those who meet the arbitrary and ever-changing criteria of mental disorders. They include more public housing, supported living facilities and in-home care, more provision of respite care, tenancy laws that better protect renters and employment laws that better protect workers, support for therapeutic communities, access to affordable – preferably free – vocational and life skills training along with relief from the crippling student debt that closes off constructive and meaningful futures for so many young people at a time they're still deciding what to do with their lives … the list could go on for several more paragraphs.

But committee members probably know better than I what's needed to offer people and communities the freedom and support they need to develop safely, healthily and with hope for the future. What you have to do is turn your minds away from the 24 hour news cycle, the machinations of party politics and the short term objectives of the electoral cycle and back towards the ideals that motivated you to take up a career in the service of the people in the first place. In doing so you will be nurturing your own mental health and better placing yourselves to start addressing the mental health needs of others. You need to reconnect with your fundamental humanity.

An excellent place to start would be to focus on protecting people from our increasingly dysfunctional institutions instead of visa-versa. Withdrawing the Chief Psychiatrist's communique would represent a bare minimum but you also need to revoke recent legislation imposing punitive criminal sanctions upon non-violent protesters.

The right to protest is central to a functioning democracy and we have many reasons to be grateful to those who protested abuse and injustice in the past – not least the end of the Vietnam War, which probably did much damage to my own mental health as a child of the 1960s. Every year Sydneysiders gather at the Gay and Lesbian Mardi Gras to celebrate the role protesters played in dragging the city out of the sexual Dark Ages. Yet we now criminalise young people for trying to disrupt the business-as-usual that's eating their futures and destroying our civilisation. Yes, they interfere with money-making and upset a lot of people, but nowhere near as much as the activities they're protesting against are already doing.

Contrary to popular belief Australia's overall suicide rate has been essentially stable over the 21st Century. But youth suicide has risen significantly over the past two decades, especially in the 15 – 19 year old age group, and is now close to its late 1980s all time high.

Some have pointed to the correlation between youth suicide and youth antidepressant prescription, noting the drugs are known to increase suicidality in young people. There's probably something to that and it needs to be looked into carefully. But another possibility is that both antidepressant use and youth suicide are being driven up by common causative factors.

For the first time in Australia's history young people can look forward to lower standards of living and fewer life options than their parents had. There's the very real possibility they'll even live to see the collapse of civilisation, with their own lives or those of their children thereby rendered nasty, brutish and short. That the resultant sense of hopeless inability to influence their own fate may be driving some into depression and suicide seems a very plausible hypothesis to me.

The last thing we should be doing is denying young people the right to publicly express their fears and anxieties or taking the actions their leaders and elders seem unwilling or unable to take to seriously address the emergency our society, species and planet is facing – even if doing so is inconvenient and upsetting to us. I'm not so arrogant and paternalistic as to suggest what form or direction their activism should take but I will categorically state we need to get out of their way and let them find their own means to contribute to saving the future from the depredations we continue to inflict upon it. They're the ones who'll have to live there. They may not have the answers yet or ever find them, but denying them the right to try is to also destroy their present. We've already failed them. We need to stop trying to make them fail themselves.

If NSW parliamentarians want to start improving the mental health of people in this state they need to stop doing things likely to make it worse. Trying to deliver 'appropriate' mental healthcare even as you continue to undermine public mental health is – to mix a metaphor – the equivalent of applying band-aids to the Titanic.

Is mental healthcare appropriate if it doesn't work?

In 2002 I attended a seminar in the NSW Parliament Theatrette given by psychiatry researchers who had made a disturbing discovery. This was the first I'd heard that SSRI antidepressants might increase suicidal ideation in young people.

It was attended mostly by mental health clinicians, academics and students, some of whom I knew from other conferences, seminars and lectures. The drug the researchers had studied was paroxetine, sold in Australia by SmithKline Beecham (now GSK) under the name *Aropax* and then the most widely prescribed SSRI in the country. Its known list of side-effects was already extensive, including increased risk of breast cancer, loss of male fertility, birth defects, gestational hypertension, hyperprolactinemia, cognitive impairment, weight gain and akathisia. Now we were being told it actually aggravated one of the conditions it was purported to treat.

Over a decade later GSK was forced to disclose the raw data from one of the randomised controlled trials used to promote paroxetine – the infamous Study 329 – which disclosed its own testing had not only revealed the suicidal effects of the drug upon adolescents but showed it offered them no significant antidepressant benefits over that of a placebo.

During the break between the researchers' presentation and the Q&A that followed I spoke to some clinical psychiatrists of my acquaintance and eavesdropped on the conversations of several others. Only one questioned the researchers' findings but none indicated they'd be changing their paroxetine prescribing habits as a result. The most common reason they gave was that though *other* clinicians were clearly prescribing paroxetine irresponsibly their own care and experience ensured they'd only give it to people who would benefit from it.

But the most disturbing rationalisation came from a paediatric psychiatrist I knew, respected and personally liked. "These are desperate suffering people", he told me, "We can't just do nothing".

Along with pain, mood disorders are the conditions that respond most strongly to placebos. They also tend to be cyclic – even in unipolar depression – with people typically seeking medical help when they're at their worst. So it's unsurprising doctors often see improvements in patients given SSRIs even if the drugs themselves lack clinical efficacy. It's also understandable patients and doctors alike might attribute any improvement to the medication.

Does that mean we should offer depressed people coloured sugar pills to avoid the expense and side-effects of antidepressants?

In 2017 a multinational team of psychologists and epidemiologists reviewed the relationship between access to mental healthcare and the prevalence of common mental disorders in Australia, Canada, England and the US from 1990 to 2015, over which time the delivery and expense of mental healthcare – particularly medications – had increased substantially in all four countries.

The Canadian results were null, showing no significant changes in the prevalence or severity of mental disorders despite large increases in both medication dispensation and clinical care.

The US figures were more mixed. The increase in treatment was accounted for almost entirely by drug prescriptions – primarily antidepressants – but there was no evidence of overall improvement in mental disorders or psychological distress and some indications the situation had gotten worse.

The results for Australia and England were unambiguous. Despite major increases in investment in mental health care – including medication, CBT, 'talking treatments', the mental health workforce and, latterly, e-therapies there was no evidence at all of a reduction in the prevalence or severity of mental distress or disability. In fact the trends seemed to be in the opposite direction.

The researchers controlled for economic conditions, natural disasters and physical health and though steady increases in obesity and diabetes in all four countries may have contributed, there were no clear indications any of those factors sufficiently explained the failure of increased mental health access to improve outcomes.

They also looked at the effect of increased awareness and public discussion of mental health issues and though it was possible the increased willingness of people to seek help explained the failure of extra investment to bring down the prevalence of mental illness it couldn't account for the lack of change in severity of reported symptoms.

When they considered the quality of treatment and its adherence to official guidelines they found a more likely explanation for the problem.

Barely a quarter of Australians who sought help for mood disorders received an evidence based intervention, with many of those failing to receive 'adequate' treatment – though it's not clear how much of the latter is because of substandard health care and how much is due to patient non-compliance or drop out. The targeting of treatment was also non-optimal, with poor alignment between those who received it and those most likely to benefit from it.

Researchers noted there had been very little effective investment in preventative measures, with ad hoc and poorly assessed initiatives in Canada and the US, a recently implemented program in England that was yet to show results and almost nothing in Australia.

While the results of the study are far from definitive they underline the fact you can't just throw money at mental health care and expect measurable improvements in public mental health. I leave it to the committee to decide whether doing something expensive that can't be shown to work is better than doing nothing at all.

One example of such a policy is the '*headspace'* mental health initiative of the National Youth Mental Health Foundation, which offers a range of care and support for people aged 12 to 25 who may be at risk of mental health problems, but doesn't accept referrals of those who are suicidal or have been diagnosed with ADHD or autism spectrum disorders – which accounts for a significant proportion of young people seeking mental health care.

Despite having more than 150 support centres across the country, receiving over half a billion dollars in Federal funding since 2017, constant appeals for private donations and a plethora of glowing assessments from its own well resourced PR machine, independent studies into the effectiveness of *headspace* have failed to show significant mental health improvements or service satisfaction among its clients.

A KPMG review of *headspace* services found many clients exasperated by long waiting times for consultations – a problem endemic across Australia's mental health systems. But *headspace* seems to be gaming its performance indicators in that regard, by offering fairly quick initial assessments – which primarily consist of filling out forms – followed by much longer waits for practical assistance. By doing so they're able to give the impression to everyone but the clients they're responding quickly to their needs.

An Australian study published in the Journal of the Canadian Academy of Child and Adolescent Psychiatry warns Canadians off adopting a similar model in their own youth mental health system due to its duplication of services, lack of evaluation of outcomes, failure to co-ordinate with existing services and large consumption of resources.

Perhaps most damning was the study performed by *headspace* managers and employees themselves and published in the Medical Journal of Australia, which admitted the data for outcomes was 'scarce' (i.e. they don't collect it) but found 36% of clients in their small sample reported significant improvement in symptoms, 51% had 'no change' and 13% had significant worsening. Sounds good? Not when you realise they used no control group and the results they report are more or less in line with those who have similar conditions to those treated by *headspace* but receive no treatment whatsoever. However the results were spun on the Orygen website as demonstrating the effectiveness of *headspace* programs. Orygen has major links with *headspace*, including an overlap of senior personnel involved in the study.

Again, lack of evidence for efficacy isn't evidence for lack of efficacy, but the difficulties in empirically evaluating mental health services should serve as a warning to avoid lopsided investment in specific organisations or treatments. The more money an organisation has the more will go into public relations and the better able to attract even more money it will become. This is likely to starve alternatives and reduce the options available to those seeking care without providing any real assurance the money is well spent.

The use of Community Treatment Orders

When I first saw the provisions of the communique of the NSW Chief Psychiatrist offering guidelines on how clinicians should interpret ‘serious harm’ when deciding whether to issue involuntary treatment orders in accordance with the Mental Health Act I was gobsmacked. It struck me as something Hanna Arendt or Michel Foucault might have used half a century ago as an example of the hubristic excesses of unaccountable power, not as a thoughtful interpretation of legislation operating in a 21st century democracy. I can’t see how it could be in keeping with the spirit of the legislation, the intent of the legislators or the needs of sufferers.

A few months ago a member of this committee put a hypothetical to me in regards to whether the risk of ‘serious harm to reputation’ was an appropriate trigger for an involuntary treatment order.

I was asked to consider a ‘respectable’ citizen of a town running down the main street naked whilst presumably undergoing a mental health crisis. Would it be acceptable to compel her to submit to psychiatric treatment as a means of salvaging her public image?

Setting aside the question of how such an extreme and even potentially life-threatening response to an embarrassing but essentially harmless instance of public nudity might save someone’s reputation I think the answer is best illustrated with a story from NSW’s relatively recent past.

When I was an adolescent homosexuality was a mental illness and same sex activity a criminal offence. To be publicly outed as gay was devastating to one’s reputation (and still is in some quarters). ‘Recidivist homosexuals’ dragged before a court could expect a custodial sentence, but there were learned jurists who were sceptical the NSW prison system was the best place for overcoming such tendencies. Fortunately the more enlightened members of the bench had an alternative.

In the 1960s and 70s there was a high profile psychiatrist widely credited with reforming the appalling conditions prevailing in Callan Park Hospital for the Insane during his tenure as Medical Superintendent. His public profile and reputation was comparable to that of Patrick McGorry or Ian Hickie today, but like some other celebrity medicos some of his colleagues expressed serious reservations about his conduct that weren’t easily dismissed as professional jealousy. Among them was his enthusiasm for psychosurgery, which saw him and his team at the NSW Neuropsychiatric Institute performing over half the lobotomies and leucotomies in Australia at a time those procedures were increasingly understood to be more harmful than helpful. There were ultimately successful calls for an inquiry into the frequency of psychosurgery in NSW – which was considerably greater per capita than in other Australian jurisdictions – that would almost certainly have taken some of the burnish off his image. But fate intervened and today the neurosurgery that contributed so much to his fame and notoriety is almost forgotten.

The psychiatrist’s name was Dr Harry Bailey.

Dr Bailey believed the mental illness of homosexuality was an instance of Freudian sexual immaturity ultimately rooted in faulty brain development *in utero*. As it happens, he believed the same thing about exhibitionism and other forms of psychosexual deviance. But he had the answer. By performing a *cingulo-tractotomy,* in which he delved deep into the patient’s frontal lobe to remove offending brain tissue near the corpus callosum, Bailey could ‘cut the gay out’ and give the criminally insane an opportunity for normal sexual development.

Progressive judges and magistrates were enthusiastic and began offering convicted homosexuals and exhibitionists a choice between significant prison sentences or going to Bailey for ‘the cure’.

The Catholic Church too saw an opportunity to signal its Vatican II modernism and began sending sodomite priests and lesbian nuns to undergo state-of-the-art surgery that would help them overcome their sinfulness. Given the options Bailey's patients were offered, to call their treatment 'consensual' would be misleading.

I've seen no accounts by people who've claimed they'd been 'cured' of homosexuality by Bailey's ministrations but I've read several that say his patients 'were never the same again'.

Eventually the Slattery Royal Commission into NSW mental health services was called, primarily to investigate the use of coercive psychosurgery at the NSW Neuropsychiatric Institute and the Chelmsford Private Hospital at Pennant Hills – both of which were directed by Dr Harry Bailey. But its initial intent was derailed before it began hearing evidence.

For over a decade there had been complaints about the lethality of the Deep Sleep Therapy (DST) carried out by Bailey and his colleagues at Chelmsford. They came from permanently disabled survivors, friends and families of those who died, the staff of nearby public hospitals which had admitted a steady stream of seriously ill and dying Chelmsford patients, the nursing staff at Chelmsford itself and even investigative journalists at the Sydney Morning Herald. The NSW Health Department, medical regulators and professional bodies all stood by and did nothing as the death toll mounted. Eventually at least 24 people would die under DST with another 19 committing suicide immediately after treatment. There's no agreed count of how many suffered permanent brain damage, with estimates ranging from 2 to over 200. As with Bailey's neurosurgery patients some of his DST subjects had been referred to him by NSW courts, mostly for drug offences.

Finally a series of 1980s exposés on *60 Minutes* led to the public scandal which forced authorities to act and the Slattery Royal Commission was hastily retargeted from neurosurgery to DST. Justice Slattery heard not only that basic standards of medical care and ethics were routinely ignored at Chelmsford, but Bailey had some of his heavily sedated female patients brought to his home overnight and returned to the hospital in the early morning. With his once sterling reputation in tatters and criminal charges imminent Harry Bailey killed himself with the same DST barbiturates that had seen off so many of those entrusted to his care.

Slattery found Bailey's surviving colleagues, Drs Ian Gardiner, John Herron and John Gill, to be arrogant and dishonest witnesses who "relied on no expertise but their own". He recommended they be investigated by the DPP for possible criminal charges but instead they eventually faced disciplinary hearings before the Medical Tribunal, leading the High Court to issue a permanent stay of proceedings against them. To the dismay of many Slattery made no serious findings against the State or professional regulatory bodies for ignoring warnings about Chelmsford for so long nor recommended recompense for surviving victims.

Bailey and his colleagues are no more typical of mental health professionals than Antony Waterlow is of people diagnosed with schizophrenia. To suggest their actions somehow justify undermining the human rights of all arrogant North Shore psychiatrists would be asinine. But unlike the tiny proportion of mentally ill people who commit serious crimes, Bailey et al were able to kill and seriously harm with impunity for well over a decade while authorities studiously looked the other way; with some even collaborating by sending fresh victims. Such is the power of the 'doctor knows best' technocratic mindset which continues to inform mental health policy and practice in NSW.

The rise and fall of Harry Bailey also illustrates the tendency of mental health diagnoses and treatments to be fad driven, not anchored in good scientific evidence and prone to retrospective recognition as abusive and harmful to those they purportedly help; prior to being swept under the carpet and forgotten. The history of mental health is replete with such examples and I have little doubt some of our current practices will be looked back upon with shame and horror within a few decades; not least the rampant drugging of young people struggling to meet the demands of our education system with substances that have not received sufficient research into their long term effects on developing brains.

In 2013 Professor Merrilyn Walton wrote an article for *Australasian Psychiatry* opining that little had been learned from the Chelmsford scandal. She concludes -

> *Today's medical students have not heard of Chelmsford; these are our future doctors. Patients generally and particularly those with mental illness are still not provided with complete information about the benefits and risks of drugs and treatments. Some still have the wrong treatment. Many therapies and treatments lack evidence of effectiveness. Many doctors are still reluctant to report colleagues who are unethical or unsafe. Doctors are still performing procedures without proper preparation and assessment. Doctors' rooms are not required to maintain minimum standards.*

The power differential between mental health professionals and their clients is such that great care must be exercised to ensure treatment is properly informed and truly consensual. In its absence, what's happening is not therapy at all but replication of the abuse and trauma underlying much emotional and psychological suffering. If you're part of a community routinely subjected to disempowerment and discrimination – which includes those with serious mental illness diagnoses as well as racial, religious and sexual minorities – you don't need to be paranoid to want to give the NSW mental health system a wide berth to avoid having your medical autonomy stripped away and being forcibly subjected to potentially harmful treatments.

According to the NSW Mental Health Commission, in 2018 there were over 28,000 people subjected to involuntary mental health orders in NSW, with CTOs accounting for about 5600 of them. A study by Edwina Light of Sydney University found the number of people under NSW CTOs rose steadily from 37.4 per 100,000 in 2005 to 48.1 per 100,000 in 2016 – which is high by world standards – despite lack of evidence for their clinical effectiveness or clear policy statements as to what they're meant to achieve.

We should not be seeking to lower the threshold at which involuntary medical treatment is imposed, no matter how much easier it may make the jobs of health bureaucrats. We should be following the advice of the Mental Health Commission and seeking to *decrease* the rate of inpatient and community treatment orders. I'd go further and say we should be aspiring to *abolish* all forms of coercive mental health care; including CTOs, involuntary hospitalisation, seclusion and the use of both physical and chemical restraints. To do otherwise is to render the phrase 'access to mental health care' a sick euphemism for 'access to institutionalised abuse' for the disempowered and vulnerable.

Alternatives to police for emergency mental health responses

Minimising the involvement of police in responding to mental health crises is a measure whose time has well and truly come. Patient groups want it, human rights and mental health advocates want it, death in custody activists want it and so to do the majority of police. It's already being implemented in various forms all over the world, with the London Met the latest to announce they're getting out of the business of emergency mental health response.

The question isn't whether the NSW Police will follow suit. That will happen sooner rather than later, with Kevin Morton of the NSW Police Association already threatening his members may begin refusing to respond to mental health call outs. The Police Association is one of the very few Australian unions who retain industrial muscle and they're not afraid to use it; for good or ill. While Morton's dummy spit at the NSW Coroner is irresponsible and self-serving he is absolutely correct in saying police shouldn't be leading responses to mental health crises. His own attitude in claiming police who kill mentally ill people are hard done by despite none ever having been convicted of unlawful killing while on duty is strong evidence for that.

I'm not suggesting for an instant police involved in mental health call outs that go tragically wrong aren't profoundly affected or undeserving of our sympathy and support. I've seen plenty of evidence to the contrary in my deaths in custody work and they have my sincere sympathy and compassion. But the standard official NSW police response of blaming the deceased for their own deaths, often by vilifying their memories while their shocked loved ones are still trying to come to terms with what happened, speaks strongly of a culture lacking the empathy needed to respond constructively to those in crisis.

Several years ago I was forced to make a 3am emergency call to try to get help for my obese, middle aged neighbour who was lying in the middle of our darkened street reciting poetry into the night sky, apparently oblivious to everything around her. I'd been concerned about her clearly deteriorating physical and mental health for some time but wasn't ready to deal with this myself. She was difficult to see, in danger of being run over and not responding to my attempts to communicate.

When the dispatcher asked me if she was having a psychotic episode and I reluctantly admitted she was he told me she was dangerous and to stay away until police arrived. I decided against telling him I too was prone to psychosis and neither I, my neighbour nor any of the other people I knew with psychotic illnesses were dangerous but I did insist she posed no threat and was scared of police. One of her prominent delusions was that the Catholic Church and NSW Police were out to get her because she 'knew too much' about clerical sexual abuse. I told the dispatcher police weren't necessary and would probably aggravate the situation and what she needed was an ambulance and mental health assessment. I then went back outside with a torch in case I had to direct traffic around her while I waited.

The police were first to arrive.

One was a calm, affable senior constable but the other an aggressive Highway Patrol officer who strode back and forwards close to her head while barking threats and commands that she should get up and get off the road. My neighbour remained motionless and apparently oblivious. When he threatened to use his taser on her I intervened at what felt like some personal risk. Fortunately he backed down and said he was joking, but if my neighbour had been agitated and aware instead of passive and oblivious she'd likely have panicked and the situation would have quickly escalated.

I've lost count of the coroner's reports I've read recommending police training in mental health sensitivity, de-escalation and conflict resolution and I know some of the recommendations have been implemented. But the culture of the NSW police is such that those lessons are rarely applied in a real life crisis. They're wired to take command of the situation and enforce compliance with their instructions, with force if necessary. Many are dealing with unresolved traumatic stress themselves and are on a hair trigger.

One of the unbearably tragic DIC cases I attended was that of Edison Berrio, who died only a few blocks from Parliament House. His killer, Constable Reuben Sakey, had been in a terrible state after almost being shot with his own weapon a few weeks earlier. His pleas for more leave and counselling went unheeded and he was armed and sent back onto the street despite knowing full well he was unfit for duty. One shot, so many victims; not least the shooter himself.

But NSW Police still managed to make things worse, by issuing a series of false and defamatory statements about Berrio that were repeated by the media and harassing and threatening his friends and family after they'd protested Sakey's eventual (and inevitable) acquittal. When Lee Rhiannon made a speech in parliament supporting Berrio and his community and decrying his killing the NSW Police Association sent a delegation to her parliamentary office to shout abuse at her and her staff.

So yes, it's high time we found alternatives to the police for mental health crisis response. That may be the closest thing to justice the families of the dead will ever see. But also important is training emergency dispatchers so they aren't potentially escalating crises by priming those present with their own prejudices about the mentally ill. Most people would assume an emergency operator would know what he's talking about. If a dispatcher convinces a caller she's in danger she might demand a police response anyway.

As the committee is aware, there are already alternative models operating on a small scale in Australia. I've no doubt they have important lessons to teach us about what works and what doesn't and they should be provided with training resources so they might replicate some of their successes and hopefully avoid the need for others to relearn some of their harder lessons.

I must admit I'm not in a position to effectively evaluate them and I hope the committee doesn't neglect talking to some of their 'clients' to get a more complete story of how effective and accepted they are among those in the communities in which they operate.

I also hope the committee will take note of the eight week online CAHOOTS training course offered by White Bird Clinic in Eugene, Oregon, which costs US$4,000 for five participants but can be free for non-profit organisations. CAHOOTS are probably the most experienced and successful non-police alternative responders to mental health crisis and while they're the first to admit their program isn't clonable into every community and situation the extent of their experience is without parallel. In particular, they now have extensive knowledge of what can go wrong or right in programs that try to emulate their success and I'm certain they can offer invaluable advice.

I must admit I'm a bit leery of having NSW Health run such programs, especially under the supervision of local area health services. I've known several people with psychotic conditions who have antagonistic relationships with their local health service, mainly due to a shared history of heavy-handed enforcement of CTOs and have my doubts they could establish the trust and rapport needed to make such a service work. Sadly, I've also known health officials who don't hesitate to abuse their power to enforce involuntary treatment and impose punishment upon those they don't feel are cooperating and I'd hate to see them with authority over crisis response. I'm certain the success of such a program depends primarily upon healthy relationships between responders and the relatively small number of people likely to generate the majority of call outs.

I'd like to see community groups offered a role, especially in communities with large Aboriginal populations. That's how CAHOOTS got started and I fear a top-down bureaucratic program will lack the capacity for personal engagement needed to make this work. Diverting disturbed people from busy emergency rooms is a worthwhile objective of itself, but if we want to reduce the potential for lethal interactions I think those who are primarily responsible to the local community they're meant to serve are more likely to produce the desired results.

Recommendations

1. NSW Parliament should immediately commission research into how best to progressively reduce compulsion and coercion in mental healthcare with a view to eventually eliminating it entirely. A good place to start would be the report of the Royal Commission into Victoria's Mental Health System, though the implementation of its recommendations leaves much to be desired thus far. The 2014 Strategic Plan of the Mental Health Commission also offers useful principles for guiding policy and should be evaluated to determine what progress is being made in implementing it.

A functional mental health system must be rights focused and responsive to the needs of those it's meant to serve. You can't bully people into good mental health.

2. The guidelines on enforcing the involuntary treatment provisions of the NSW Mental Health Act contained in the communique of the NSW Chief Psychiatrist should be withdrawn at once and a rights focused replacement issued.

It should remove references to vague, subjective 'harms' such as 'emotional/psychological harm', 'financial harm', 'harm to reputation or relationships' and 'neglect of self'. It should explicitly call for the risks of not treating a condition to be balanced against the assessed risks and benefits of a proposed treatment. Consideration should also be given to the risk of provoking violence and the resultant physical and legal harm inherent in coercive medical treatment.

Dr Murray Wright may not be the best person to write it.

The current guidelines are so broad and over-reaching they could never be implemented comprehensively and consistently. They will inevitably continue to be enforced selectively and punitively against the most vulnerable in our community by the worst of our health officials. They fly in the face of the principle that coercive mental health treatments should be a last resort. They're a shameful stain on our entire mental health system, intimidating those most in need, empowering petty tyrants and promoting stigma.

3. There needs to be well informed, up-to-date, non-judgemental advice and support for those wishing to come off prescribed psychoactive drugs, including pain killers, addiction substitutes (e.g. methadone, buprenorphine) and psychiatric medications. A centralised helpline would be a cheap and easy start, but consideration should also be given to offering in-home monitoring and support and publicly funded clinical assistance to those struggling with withdrawal. Titratable substitutes, such as liquid forms of the drug where available, should be made available on the PBS or under state government subsidy for the purpose. And doctors should be educated and encouraged to inform patients of the difficulties they may encounter trying to come off a drug before prescribing it.

4. I know I've been saying this for over 20 years to no avail, but I've got to say it again. The NSW prison population must be significantly reduced. Diversionary programs must be implemented on a much larger scale, especially for young people, those with psychological and cognitive impairment and Aborigines. Much can be gained by replacing as much of our retributive justice system as possible with a restorative one, not least budget savings. More practical support must be given to those leaving prison to ensure they won't soon be back, but the best answer is to avoid putting them in prison in the first place.

Australian prison systems dodged a bullet during the initial COVID outbreak. There will be more pandemics over coming decades and our luck will eventually run out. When it does we need to have a much smaller prison population than we do now if we want to avoid catastrophe.

5. Mental health funding eggs shouldn't primarily go into one basket, as has been the case with *headspace* in Federal funding of youth mental health. A larger number of small scale, local, decentralised, community based initiatives will not only give those needing help a greater range of options but will also be more responsive to the needs of those they're meant to serve.

6. Target based performance indicators are unlikely to be useful in ensuring services are offering a good bang for their bucks. They're not only prone to gaming, they serve to shift organisational focus onto the surrogate end points used to assess their performance and away from developing rapport with the people they're meant to serve. Effective mental health care is a profoundly human endeavour not well served by a slick, 'efficient' institutional machine.

7. There needs to be a centralised, publicly accountable, transparent complaints handling body for those dissatisfied with their mental healthcare. It should probably table regular reports in Parliament to be immediately put on public record while, of course, protecting the medical privacy of complainants. But the latter consideration should never be used as an excuse for denying patients access to their own records, an abuse of process I've seen more than once.

The MHRT has become embedded with the authorities it's meant to regulate and has well and truly outlived its utility. It should be abolished and replaced with something less elitist and more representative of those who seek mental healthcare. The nexus between the NSW mental health and legal systems has time and again proved its inability to deliver responsive oversight or protect the human rights of those seeking help. We need to stop doing the same thing over and over while expecting different results.

8. Much of the focus of NSW mental health policy and funding should be preventative and non-medical in nature. There is much more to be gained with the provision of secure, affordable housing, meaningful, non-exploitative employment, assistance in living at home with disability, anti-bullying programs in schools and workplaces and support for struggling families with young children than there is in rolling out the latest therapeutic innovations or ensuring everyone has access to psychiatrists, psychologists, counsellors and pills.

9. NSW parliamentary researchers should gather as much information as possible about the work and effectiveness of services around the developed world that replace police as first responders to mental health crises. Particular attention should be paid to how despatching is handled and how situational dangerousness is evaluated and responded to.

While there's merit in keeping people in emotional crises out of hospital emergency rooms consideration must also be given to the possibility their condition has a serious physical cause – such as drug overdose, adverse reaction to medication, seizure, fever or brain injury – and response teams must be trained to recognise the possibility and act accordingly.

The metric for evaluating such programs should be the avoidance of death and serious injury. Surrogate measures such as cost savings and reducing demand on other emergency services should be collected, but shouldn't serve to take the eye off the ball, which in this case is human life.

When the data has been gathered and considered, parliament needs to make decisions on the best way(s) to implement such programs across the state, while keeping in mind different communities will pose different challenges and may require different solutions. Community members should have a clear path to making their own opinions heard in developing their local services – especially those who’ve had serious mental health crises or consider themselves at risk of having them or having to deal with them.