Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF MELANIE HILL

I, Melanie Hill,[1] say as follows:

1 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

2 This statement is about my experiences with the mental health system involving my daughter, Natasha. She is now 16 years old and suffers from significant mental health issues that impact every aspect of her life. She currently has a diagnosis of borderline personality disorder.

Background and nature of Natasha's illness

3 Natasha suffered from significant trauma during her early childhood, although I didn't find out about that until she was 14.

4 When she was 8 years old, and living with me, she starting showing signs of anxiety and had some behavioural issues. She started seeing a private psychologist then escalated through the public system.

5 We first went to an emergency department when she was around 9 years of age, after she appeared to be having panic attacks and dissociative episodes. We sat there for hours. They did a risk assessment and sent us home. This happened a number of times over the next few years but she was not admitted as an inpatient.

6 There was a time when she was saying she wanted to die and holding knives to her arm. I contacted a triage service and I was directed to a local mental health service. Natasha had a few appointments, then an assessment. She was diagnosed with generalised anxiety disorder and oppositional defiance disorder. She was prescribed medication by a GP at age 10 due to increased anxiety, panic attacks and rage episodes.

7 The severity of Natasha's mental illness escalated when she was around 12. Her panic attacks and dissociative episodes increased. There was a time when she tried to kill me and I had to call the police.

[1] The name and details of the witness (and others) referred to in this statement have been changed to protect their identities.

8 By this time, Natasha had seen many mental health practitioners including a child psychiatrist, two psychologists, infant and child mental health services, early life mental health services, attended equine therapy, and had attended an alternative stream of schooling that included mindfulness, yoga and meditation practices within the curriculum. We had been to hospital emergency departments three times by this stage.

Hospital admission and events that followed

9 On Labour Day weekend in 2015, Natasha went missing. She was 12 years old. My dad and I found her in a park with no shoes on and she was disoriented. She would only get in the car if we took her to the hospital, as she wanted to be admitted.

10 On the way in the car she assaulted my father and tried to cut herself with a shard of glass. Natasha was stating that she had a plan to kill her younger brother. Her voice was different and she was not her usual self. It was very scary.

11 We took her to the hospital and I was sure she would be admitted. After waiting until 1.00am we were told by a mental health nurse that this was conduct disorder and that she was to go into residential care or to live with another family member due to the risk of harm. We did not meet with or speak to a psychiatrist. The nurse was following directions from a phone call with an on-call psychiatrist, whom we had never met.

12 Natasha was discharged into the care of her father in Melbourne. She stayed with him for about five weeks until it broke down. She then lived with her aunt in Melbourne for about a year. I was living about an hour and a half away with my partner and Natasha's younger brother. At this time I was calling what felt like every mental health service in Melbourne to try to get therapy for the disturbing thoughts she had towards her younger brother so that she could come home.

13 On the advice of someone I respected, I found a private psychiatrist on the other side of Melbourne who I thought would be able to help. I paid over $300 a session for her to see the psychiatrist, but Natasha only went to a couple of sessions and then refused treatment. Natasha's aunt and I continued seeing the psychiatrist to get support. I also attended a 12-week group for carers in Preston which was brilliant.

14 Around the same time I made contact with a child and adolescent mental health service. I attended a session without Natasha and felt that I was treated poorly. Due to Natasha not wanting to engage, they could not work with her. I was reaching out and making contact through email and phone calls to get help one-on-one for myself, to get support to build and repair my relationship with Natasha, but I did not get any appointments. I followed through with the complaints process.

15 While Natasha was in Melbourne, I was travelling a lot to help her whilst also looking after my family and working. In the year that she spent with her aunt, Natasha's mental health declined, her school attendance and engagement was dropping, her self-harm was increasing, and she started using drugs. One year after Natasha's aunt took her in, it broke down and Natasha's aunt could not care for her anymore due to the complexity of the situation. As a result of lack of treatment and her refusal to come home, Natasha was put in residential care in Melbourne.

16 For the six months following, Natasha spent a majority of her time on the streets with her boyfriend, using drugs and sleeping rough. She told me that she experienced additional traumatic events during this time, but would not elaborate. I was terrified. I often searched Melbourne streets showing people her pictures so I could find her. She was only 14 years old.

17 I was working with every service involved to help her. Natasha was put into secure welfare twice during this time, but they could only hold her for less than a week each time. During this time, I contacted a governing body for mental health services many times due to feeling completely powerless and aghast at the lack of services for Natasha.

18 Natasha was later put in foster care for one night. I had been caring for her in Melbourne due to her declining mental health for the week before she spent her first night in foster care. I alerted, what I thought were the appropriate services, as to my grave concerns for her safety, but nothing was done.

19 That night she cut up her arms and legs with a razor all over and the foster family called the police due to the distressing situation. I believed that I would be called during the night and had slept in my clothes. When I got the call, I went straight to the hospital. I spoke with one of the mental health staff there and they advised me that this was a very serious situation but that they would not be admitting her to the psychiatric ward that night.

20 I pleaded with them and alerted them to the risk of sending her home, but they just tended to her wounds and gave her a sedative and sent us home anyway. We went to her aunt's place for the night.

21 Before we left, they told us that someone would be in touch first thing in the morning and that if Natasha didn't engage, they would send police to section her. Nobody called and nobody came. I called the hospital mental health team in the afternoon, after trying desperately to keep Natasha there to be seen, but they said that no one was coming and that I should follow the risk plan. There was no risk plan. Natasha took off that

afternoon. I had no idea where she went, but it was back to her boyfriend and the streets.

22 Not long after that, Natasha was put back into secure welfare. She had broken up with her boyfriend after more traumatic incidents. Natasha finally agreed to come and live with me. I took six months unpaid leave from my job and left my family home to rent a place for Natasha and myself so I could care for her one-on-one.

23 I lived with her for 14 months whilst my son was living with my partner. During that time I managed to stabilise Natasha and get her back to school and engaged in therapeutic services and case management. Things were going well for a time, but Natasha returned to drugs and started disappearing. Her self-harm escalated to the point of needing stiches. We had a few visits to the hospital to be stitched up in that time.

24 Natasha's behaviours escalated to a point that I couldn't manage. Her behaviours were serious enough to have our tenancy at risk. At this stage I had a break down and I ended up in emergency. It was not long after that that Natasha went into residential care closer to home. This was a very difficult and painful choice we made together to preserve our relationship, after trying many ways to make it work.

25 Natasha was later assaulted in a burglary. She called me and said that she felt that she needed to go to hospital and was suicidal. She was assessed by a child and adolescent mental health worker at a hospital. I was told they would arrange for her to be admitted as a voluntary patient the next day and that they would call us the following morning. Nobody called.

26 I called in the afternoon and they said they had been given the wrong number. They told me no arrangements had been made for her to be admitted. By this stage, Natasha was highly irritable and I had her at home and was trying to manage this. I contacted a governing body for mental health services and soon after had a call from the head clinician from the child and adolescent mental health service. I then had to tell our story again. They said that they needed to do another assessment, so Natasha had to tell another worker what was happening for her and then I had to take her in for an appointment so that she could say the same stuff again to another worker. Natasha went in to speak and not long after came out of the room yelling and screaming. She had a rage episode; she was smashing things. Natasha said that they were not going to admit her to hospital. Amidst the rage, they organised for a referral to the psychiatric ward, but we had to wait hours to find out if they had a bed. She was eventually admitted to hospital as a voluntary inpatient.

27 The following night Natasha was placed in a locked ward due to an incident involving her becoming violent towards a worker. She was released after two nights. I was told it

was not therapeutic and Natasha wanted to leave. While she was in the ward, Natasha was given a lot of Valium and was also given a diagnosis of borderline personality disorder. Natasha did not remember being given the diagnosis. I was unable to acquire the discharge summary and had to apply for this information through Freedom of Information. Everything that happened in this time was shocking to me.

28 Natasha was released back into residential care. About four months after that she became suicidal again. She came home completely dishevelled. I took months off work to be with her and care for her in the family home.

29 The following day her Child and Youth Mental Health Service worker came and assessed her. The team psychiatrist, who had met Natasha before, recommended sectioning even though Natasha wanted to go to hospital. A week later she was still at home.

30 I was told there were no beds and that they were looking all over Victoria. At this stage, I was not told that the reason it was so hard to find a bed was that Natasha had an alert on her file that she was only to be placed in the locked ward (also known as the high dependency ward).

31 After an incredibly distressing week it became too much and Natasha had a major panic attack. It turned into what looked to me like a psychotic episode, but I was later told that it was a dissociative episode. Myself and a friend transported Natasha to the hospital and we were ushered straight into a private room due to Natasha's highly distressed presentation. Natasha was given an anti-psychotic drug and after a while came out of the state she was in. Due to this and other contributing factors that I made clear to the staff, Natasha was sectioned in emergency.

32 Natasha had someone sitting at her bedside 24 hours a day. Natasha was then moved to the paediatric ward. Later that night we found out that she had a bed in a psychiatric ward in Melbourne. Natasha was feeling hopeful.

33 The next morning she rang me in tears and told me she was in the locked ward on her own with two workers just staring at her. By this stage, Natasha had not showered in weeks; her hair was all matted and smelt like compost. Natasha spent a week in the high dependency ward. During this time I had a meeting with the staff and Natasha's care team.

34 I felt that I was treated poorly in this meeting. The staff told a member of the care team during the meeting that they had also diagnosed Natasha with antisocial personality disorder. The staff did not speak directly to me about this. I was very distressed. I made a complaint soon after.

35 The hospital released my daughter from the high dependency ward after less than a week. We were ushered out the back way of the ward with security guards due to Natasha's highly distressing presentation. She was shaking and muttering to herself, crying and I needed to assist her to walk. They had given her Valium which had not kicked in yet. When we made it to the front of the hospital I had to stop Natasha from running into oncoming traffic. I had to sit with her for a long time whilst she sobbed on the street stating that she wanted to die. I had to wait for the pills to kick in before I could drive with her anywhere.

36 Natasha stayed with me for six months and she was in bed most of every day. She told me she could not face seeing anyone in the town we lived in. I had to go to work part time as we were struggling financially.

37 During this time Natasha went to a detox clinic for two short stints for drug use. The first stay was mainly for respite for myself and for social interaction for Natasha. The second detox was so that she could go to rehab. This lasted less than a week due to relationship issues and but Natasha told me she felt bullied there.

38 Natasha told me that she wanted to move to Melbourne to live in a mental health residential care service for people aged 16 and above so that she could start living a life worth living. Our family supported this decision: it was terrible to watch her wasting away. We waited a long time for the referral to go through, visited the place and then had to wait for a monthly panel to sit, during which they review the referrals. We pinned our hopes and dreams on that.

39 By December 2018, Natasha had been home, living like a prisoner, since June that year. The service said that they had beds but they would not take her. We were not told why. This was devastating and I had another break down when I heard this news because I was so worried about Natasha.

40 We had to make other plans and, with the care team, made plans for Natasha to live with her dad again in Melbourne, so she could access services since she would be in the catchment area. She could also access schooling again.

41 The weekend before Natasha started her new school, she spent a weekend with us and we noticed paranoid and delusional behaviours. Natasha was saying that people were looking at her and talking about her and laughing at her. There was also an incident on the bus the night before school that was concerning in relation to these beliefs. I alerted Natasha’s therapeutic worker of my concerns.

42 In the morning Natasha was trying to make her way to school but was experiencing these delusions and panic. I alerted the school that Natasha would need intervention when she arrived, and that her worker was on her way to meet Natasha at the school.

Natasha's worker ended up having to take her to the hospital to be assessed due to her escalating paranoia and delusional behaviours. Natasha disclosed that since being at her father's house she had taken herself off her medication.

43 Natasha ended up in the emergency department of a hospital in Melbourne. They assessed her and told us that they believed that she should be admitted as a voluntary patient, but that she would have to be put into the locked ward again. This was distressing for Natasha and she declined. I stayed in a hotel with her and got her to her GP the following day to get Natasha back on her medication. Natasha's GP understood that in times of crisis, she would not be able to access the hospital anymore and prescribed me Valium to give as needed in these times. We now believed that I was the only option to care for Natasha in these heightened times of crisis.

44 I spoke with a different hospital and found out that they could assess her as she presented and she would not be put in the locked ward unless she presented at that time as violent. I was told that was the way to avoid the emergency department was to call the triage number they gave me and get an 72-hour appointment for assessment and that she could be admitted that way.

45 Following this I had to hire an apartment near Natasha's school to stabilise her on her medication and try getting her back to school for two weeks.

46 In the second week, Natasha's mental health declined and her suicidal ideation increased. At one point I had to physically stop her from running into traffic, and after this I sat with her for two hours as she banged her head on the wall, sobbing on the floor stating that she was worthless and that I should have had an abortion. I gave Natasha Valium and prescribed anti-psychotic medication and she finally slept. During this time I called the triage number they gave me for the child and adolescent health service to try to get an 72-hour appointment and avoid the emergency department. I had to go through our story again. They said they would check if there was a bed. No one rang back. I waited all day for someone to call.

47 Following on from that, Natasha was staying with her dad and trying to stabilise. She had a week's stay in detox and made it to rehab, but struggled within relationships and left. We have found out that the residential care service told the care team that she needs to be stable at her dad's place, and not using drugs, for two months for her to get her own housing in a supported environment.

48 Since then, Natasha has struggled with severe intrusive thoughts about suicide and other very personal and disturbing thoughts that she has been reaching out for help for now for years. Natasha has still been unable to move through rapport-building with a therapist to work through the trauma due to her instability and cycle of crisis.

Program

49 Around a year and a half ago, Natasha was referred to a new program run by a community service organisation near my home. It is staffed by trauma-informed workers. She has a therapeutic trauma-informed case worker. This has really helped Natasha. Natasha has told me that she trusts her and likes her. I have seen that the worker follows up on what she says she will do for Natasha.

50 The program is overseen by a psychologist that supports the carers and a psychologist that is for Natasha. They are all part of Natasha's care team and work in an outreach capacity.

Problems with the mental health system

51 I have put my hand up for help from the very beginning and I feel like Natasha and I did not get it. To me, the system does not know how to treat people and families affected by trauma. I feel like as a mother and a carer I am only seen by acute mental health services in complete crisis and then I am assessed as being crisis-driven or overly emotional. I have felt judged and misunderstood and throughout the process developed my own paranoia from my experiences in the mental health system.

52 I have had to tell our story so many times that in the end there is little effect or emotion and each new person treats you differently. I have such a distrust for the system.

53 Natasha has told me that she distrusts the system too. When Natasha has reached out for help, I have seen that she has been rejected, or that she has to wait ridiculous amounts of time to get help that is usually too little, too late.

54 Access to acute mental health services through emergency departments are traumatic and lengthy. They discourage people from accessing help due to the stigma and how we are treated in those moments.

55 The mental health system is focused on assessment, diagnosis and medication. There needs to be more trauma-informed training for staff. The recognition of how people are treated inside of and outside of crisis by staff is crucial to people's wellbeing.

56 Natasha has been assessed more than 15 times. She has been diagnosed with generalised anxiety disorder, oppositional defiance disorder, conduct disorder, separation anxiety, borderline personality disorder, anti-social personality disorder, post-traumatic stress disorder, complex post-traumatic stress disorder, anxiety and depression.

57 We have also been told that Natasha is likely to be on the autism spectrum, but due to Natasha's instability, we have not been able to complete the assessment formally. We also had another therapist tell us that she believes that Natasha has an autism spectrum disorder called pathological demand and avoid syndrome. Natasha has never been given the opportunity to become stable enough to move through any therapeutic relationship and to benefit from treatment.

58 We have presented at the emergency ward tens of times and have been turned away with recommendation to hide the knives, rope and other things Natasha could use to harm herself or others. Sometimes we have received a phone call for an appointment in weeks' time, which is not helpful.

59 There is a huge gap between acute inpatient services and community care.

60 We have experienced bounce-back between alcohol and drug services and mental health, with the psychiatric ward telling us, 'this is alcohol or drug related, not a mental health issue', while alcohol and drug services tell us that Natasha is 'too mentally unstable to access detox clinics or rehab'.

61 There is a big problem with access. There seemed to be a reason in every situation we had as to why we could not access a particular service. Some of these reasons included catchment areas, complexity, age cut-off, and the alcohol and drug vs mental health issues. No engagement means no treatment for young people.

Impact of Natasha's illness on her and our life

62 Natasha has nothing in her life except her immediate family. She is so crippled by her anxiety that she cannot manage friendships and only has one friend who she is heavily reliant on.

63 She is currently 16 and should be in Year 11, but she has not been in school (other than short stints) since Year 7 due to her crippling anxiety and relationship difficulties. Natasha is incredibly bright and insightful when she is well.

64 This systemic failure has impacted our family in many ways. We do not blame Natasha for any of it, but we do blame the lack of services offered for young people with chronic mental health issues. I am on medication to manage the stress and I see a psychologist. My partner and I have, with the help of Natasha, managed to protect our son from most of this, but my lack of mental presence at times and needing to leave home for long periods of time with little information is not beneficial for him.

65 Thankfully, the training I have got from my work has helped my relationship with Natasha to be incredibly strong. They ask what she has to live for and she says, 'Mum'. I feel like if we did not have that relationship she would not be alive.

Recommendations for improvement to the mental health system

66 Family is so important to early intervention. Education should be provided to families and carers to help them give support and respond to behaviours of family members with mental illness in a therapeutic way. If I had this education to start with, our relationship would have been stronger earlier and harm would have been avoided.

67 The way you are treated is so important when you are trying to access services. Staff need training around how to respond compassionately and patiently with people and their families who are suffering.

68 There needs to be a place where children with high risk behaviours can go or be taken to that is not the psych ward. There should be hubs open 24 hours where young people can go to be contained and removed from the cycle of trauma, can access teachers and education, and be with kids their own age rather than alone.

69 There needs to be a recognition that young people and children who are harming themselves in all sorts of ways need to be protected from themselves. Laws need changing to protect children. Safety needs to be put above their freedom. Parents are powerless when watching our children traumatise themselves in the community over and over, and we are unable to keep them safe. These facilities need to be long term and contained.

70 We need an option for acute care that is available before hospital. It needs to be something that is not clinical and cold, and can be done with the carer.

71 Trauma-informed care should be more widely available. I truly believe that without access to the trauma-informed program my daughter would be in a much worse situation than she is now. She would have no trust in the system and would certainly not be engaging with anyone in the system.

72 Mental health and drug and alcohol treatment should not be separate: they need to come together.

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