2019 Submission - Royal Commission into Victoria's Mental Health System

Organisation Name SUB.0002.0001.0049

N/A

Name

[redacted]

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?

I would suggest that mental health staff need to have better understanding of when people are at risk of suicide. I also would like to see more consultation of family and careers of person who is unwell. I also would like a more holistic approach to all parties concerned - the person who is unwell and the family who are trying to deal with them.I would suggest that the community particularly those who deal with people with mental health issues are more trained and more compassionate and do not just take what the person who is unwell says.

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

"In our experience nothing is working well and I would suggest that all the money that is being put into the mental health system is not going to the right areas, I do however think that for people who have mild mental health issues there is support but for more complex people the support is not good."

What is already working well and what can be done better to prevent suicide?

In the two years since my son died I have been involved in many consultations of which I am still to see any outcome. I have been trained to tell my story and again no opportunities have been presented to be involved in anything apart from the training. I think the mental health system is broken and it will take some daring and different things to mend it. According to statistics the suicide rate is rising so I dont think we have done much to improve the prevention of suicide.

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

I believe that someone who has severe mental health issues do not have insight into their issues. This was particularly so with my son who kept saying Nothing wrong with me. All good and in fact everything was wrong with him. The mental health treatment he received through three regions was appalling and one service did not talk to the other one. The emergency departments are hopeless and not a suitable way for someone to be admitted to mental health areas of the major Hospitals. I can find nothing positive to say about any of our experiences in the last six months of my sons life.

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

"I believe peopke who work in this area have been there too long. There is insufficient support and they are jaded and lack empathy, Many suicides occur after someone has spent time in the

Mental Health Departments of major Hospitals."

What are the needs of family members and carers and what can be done better to support them?
I feel families know more about their loved ones than professionals do and should be listened to. They should be included automatically in Case Conferences and not be treated as overinvolved parent or caregiver.I believe if I had been consulted or listened to my son may still be alive today.

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
More training and support and increased number of staff. I attended training for the Assist Mental Health program after my son died and the professionals were jaded and did not really want to be there. It was so painful for the people who have Llived Experience to hear some of their comments in relation to people with mental health issues.

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?
I do not have any knowledge of this as my son was not in this position.

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
I would like to see a different system than what exists today. I would like carers more involved with the person who is unwell. In my sons case I knew him better than any professional and I knew he was unwell and that it would end badly. Nobody would listen to me or his sisters and so when he died I was not surprised.

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
Not just give money to organisations who do not appear to be doing anything other than hold consultations and then not following up after this. Make Primary Health Networks more accountable and make sure people with all types of Lived Experience are included in these Networks. I feel that I have been a token person but there is no follow up afterwards. Changes are needed in how we view mental health and the complexities around it.

Is there anything else you would like to share with the Royal Commission?
"No I will forward my story separately to this submission. It is called Nothing Wrong with me All Good,"

"NOTHING WRONG WITH ME. ALL GOOD"

My son [redacted] My son, [redacted], born [redacted] 1969 took his own lifecommitted suicide on [redacted] 2017. by hanging himself.

Until the age of 36, he had a normal life and a successful career as a Real Estate Property Manager. He had no previous history of any mental health problems. In December 2005, he suffered his first bout of depression and the [redacted] Crisis Assessment and Treatment Service (CATS) team became involved. He was diagnosed with reactive depression following the break-up of his marriage and his wife and five-year-old daughter moving to Brisbane. My late Mother suffered a similar depression 30 years ago and recovered after electric shock treatment so I assumed it would be the same situation for S[redacted]. I was very impressed by how the CATS team supported S[redacted] and us at this time. He had moved back to ourthe family home during this time. It took him seven months to recover but he went back to his career.

At the end of 2012 and the beginning of 2013 he had another major depressive illness and the CATS team again were involved and were supportive once moreagain. On one occasion, he took off in his car and left his watch and jewellery behind and nobody could locate him as he had switched off his phone. The [redacted] Police became involved and he was thankfully found and taken to [redacted] hospital where he spent one night. He persuaded us, against the wishes of the Psychiatrist, to take him home. He gradually recovered and went back to work for about nine months. He completed a Certificate IV in Aged Care as he was unable to return to his previously stressful job.

In early 2015, he moved to Tasmania and stayed for six months. He did see a Psychologist down there but returned in June very depressed and a changed person. He spent the rest of 2015 working spasmodically and drinking and gambling heavily. He either lived in a flat he owned with his ex-fiancé, [redacted] in Kew or with us in North Balwyn.He was working part
time in Aged Care from April to end of September. In September of 2016, my father-in-law died and a client, he had been a carer for, also died. S[redacted]'s mental state went downhill from here. At Christmas, he was a shell of his former self and found no enjoyment in anything. His 16-year-old daughter, [redacted], came down from Brisbane as she always did at Christmas but he found no pleasure in her spending time with him and she was the light of his life. On 28th December 2016, my husband and I were on our way to the airport to fly out on holidays when [redacted] rang and said he was really unwell and was saying he was not going to be around next year. She said we had to help and she was really distressed. I immediately rang the CATS team and they said they would follow up and ring [redacted]. I also gave them the names of my two daughters to be the primary contact people while I was away. Apparently, they rang S[redacted] but he said what he always said. "Nothing wrong with me. All good".

On 9th January, we returned from our holidays and S[redacted]'s mental health state had not improved and appeared to have deteriorated further. On the 13th January, I contacted the CATS team once again as S[redacted] had not had anything to eat or drink all day and would not get out of bed. At first the triage lady told me she didn't know what they could do, but I told her about his previous involvement with them and she said she would look into it and ring me back. When she rang back the same day later that night, she assured me that the CAT S team would visit on Monday 16th as she felt that he needed hospitalisation and a longitudinal assessment. I told her I would not tell S[redacted] or he would not agree to see them. She told me not to worry. On the Monday, the CATS team rang and the man said they could not come out WITHOUT S[redacted]'s permission as he was a 47-year-old man and I should not have been told that. I tried to explain but he was very abrupt with me and I knew he was not going to come to the house. He did speak to S[redacted] who as usual said the same thing "Nothing wrong with me. All good", and I knew then that this was our final hope.

S[redacted] moved back to Kew and stayed in bed all day on Monday, Tuesday and Wednesday. He refused to go to the doctor and on Wednesday[redacted] told us he had sent a textbeen threatening to kill himself on the Tuesday and he would have to leave the flat. We immediately rang[redacted] Police and a lovely young policeman and policewoman came around. They went in to speak to him but he said the usual things and he had been drinking all day. This was 3.00pm. When they came out of the unit they asked[redacted] if it was Tuesday he had sent the text? [redacted] said yes and they apologised and stated that because of the Mental Health Act, nothing could be done as 24 hours had passed. They could however take him to[redacted] if he agreed. S[redacted] did not agree. [redacted] asked S[redacted] to leave and he wandered up the street and disappeared from view.

My two daughters, [redacted] and [redacted] picked him up later as he returned to [redacted]'s and he stayed the night with [redacted] in East Ringwood. The next day she took him to his regular Doctor in Kew as he had been saying his life was hell and he was going to kill himself. She went in with him to the Doctor's and because she told the Doctor what had happened he rang the Mental Health Department at [redacted]. Both my daughters took him to Hospital and he agreed to go and stay for 48 hours. At the end of this time he said he would go to the long stay section. He stayed there for 13 days but discharged himself on the Wednesday. The Psychiatrist also spoke with us and said they were going to discharge him at the end of the week as he had not "engaged". He ordered a taxi and tried to go back to Kew but [redacted] told him to go back to hospital. He went back to the[redacted] Sports Club, had some drinks and then tried to get back into the hospital. They told him to go to emergency, the triage saw him and said he could not return as his bed was already taken.

S[redacted] came back to his younger sister's house at 7.00 am and I came over to see him. We then spent two hours trying to find accommodation from a homeless services that [redacted] Hospital had given him. There was no accommodation anywhere.

That night he went back to [redacted]'s but did not get out of bed and just drank for a couple of days and . In the end, she asked him to leave.

He then went to stay with a friend he had met the previous yearon Tinder last year and she contacted me to let me know he was safe. She knew everything that had happened and hoped she could help. We hoped she could help too. On Friday 3rd March 2017 I received a text from her saying she had come home to find returned to the house early and S[redacted] had prepared a noose in her back yardmethod of suicidehanging noose and she wanted his date of birth to contact the Police. She and said he stated he would have to leave. I contacted her back to say that a mental health person needed to be there. My eldest daughter[redacted] then contacted her and rang me to say that the Police and someone from the[redacted] CATS team was there. At last I thought he would be taken somewhere for his own safety and once they knew his history, he would be admitted to hospital. I slept well that night thinking he was safe. I learnt later that S[redacted]'s friend in Dandenong had returned earlier than S[redacted] expected on the Friday night and she told me she was convinced he would have killed himself that evening. He was assessed as being no danger to anyone or himself that night. 38 hours later he was dead.

The next day[redacted] rang and said that they didn't do anything because they had spoken to him and he was saying his usual thing of "Nothing wrong with me. All good". He had also been drinking. His friend at Dandenong asked him to leave and he rang an older friend that day to organise permanent accommodation for them both. him. He then went to my son-in-law,[redacted] who said he could spendspend Saturday night at his home in Donvale. During the afternoon he drank with[redacted] and d a friend and he went to bed at 8.00pm.[redacted] went out the following morning and made him get up and asked him if he wanted anything for breakfast. He replied no.[redacted] then went to the shops at 11.45am and the last[redacted] saw of my son he was walking around smoking a cigarette. When[redacted] returned an hour later[redacted] had hung himself. killed himself by hanging. .

During thoseWe have spent the last six months we livedliving our own hell.[redacted] had come back to our house so many times and every time it would not work. I received so much advice from all the professionals stating I needed to let go as he was the only person who could control his life
e and I was worn out with the anxiety and worry. They assured me constantly that he would not kill himself. I foolishly believed that letting him go would save him. How wrong I was. I knew in my heart that the situation would end badly. Drug addicts need to reach the bottom before they can get well but sadly I now know that people with mental health need help - some whether they want it or not.[redacted] was incapable of helping himself and nobody would listen to me. As long as he said "Nothing wrong with me. All good", no one could help.

I know it is too late to bring my son back, but I need answers as to why nobody could help. From the CATS team who assured us he would not kill himself; the Police who were so constricted by the Mental Health Act that it needs to be an immediate threat not 24 hours old; to the person who visited him on the 3rd March ([redacted]) at 21.30pm who hadand left S[redacted] a card for him to contact someone the next day. He might have been a 47-year-old man who everyone said had the right to make choices, but he was not mentally stable and was so unwell that his right to make the choice to take his own life should have been prevented. He had deteriorated so much since 28th December, he should have been taken into hospital on the 3rd March involuntarily. I have been saying, as a mother, that I knew this is how it would end up. It's about time that Mental Health was looked at from a holistic point of view. Why did [redacted] not have access to S[redacted]'s previous history? Why did the [redacted] CATS team not visit him when his daughter was with him? Why not support a 16-year-old during this extremely challenging time?

What is wrong with the system, that one person's rights overlook the fact that other people are connected to that person. What about our rights? S[redacted] has left a 16-year-old daughter, two sisters, his father, stepfather, two nieces, two nephews and myself who are left with the question "Why could nobody help us?".

We celebrated S[redacted]'s life on 17th March and so many of the 250 people who were there had similar stories about the mental health system. I understand we don't want to go back to the past where people were placed in institutions. I accept that there are so many people who need support and to the professionals S[redacted] was just a number, but to us he was so much more. When someone with a history of mental health issues states "Nothing wrong with me. All good", perhaps it should not be taken on face value because in my son's case there was "Everything wrong with him. Not good!".

[redacted]

It is now two years since S[redacted] died. My grief is no less now than it was then. I have shared my story with so many people. I have spoken to the three mental health services that were involved with S[redacted]. I complained to the Mental Health Commission and they investigated my case. I put in submissions to the Coroner and when the Coroners Report was handed down I was disappointed with its findings as some of the reports from the Hospitals were incorrect. I decided in the end to try and accept that my son had died and that bitterness and anger were of no help. I knew that what I wanted to see was a change in attitude of the mental health professionals. We were treated so badly in the last six months and I was totally dismissed as an over anxious Mother who did not know what I was talking about.

[redacted]