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

SUB: 0002.0006.0136

[redacted]

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

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?
N/A

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

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.
N/A

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

What are the needs of family members and carers and what can be done better to support them?
N/A

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
N/A

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?
N/A

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?
"Patterns Observed in my role in Victoria currently: A very large percentage of clients: do not experience a sense of connection with anyone. (Some of these clients are socially isolated BUT others are not socially isolated by definition i.e. they live with families but still experience

loneliness) do not ever or seldom, experience meaningful engagement. Meaningful engagement can take many forms: regular employment; purposeful activities; development of self and others; service to others. who present with chronic helplessness, have an attitude of entitlement with little sense of Agency. in my opinion, are misdiagnosed with BPD (Borderline Personality Disorder). This diagnosis is more recently presenting with such frequency that it may suggest it is a *go-to diagnosis for those who are suicidal and verbalize it. (I have worked with this group (BPD clients) and understand that the nature of their disagreeableness can be one of a clinicians greatest challenges). *Often by Psychiatrists. The Deficiencies in the System Observed: Not always, but seemingly, the majority of the time, once an individual has been hospitalized for Suicidal Ideation, they are discharged with limited, if not, no support or change in medication or treatment protocol. Individual clients report to feeling a sense abandonment, rejection, helplessness, hopelessness, guilt and shame which of course adds to their risk factors. Strong pervasive resistance across the board (nurses, mental health workers, psychologists, counsellors, psychiatrists etc.) to those who are diagnosed with *BPD. (again far from ideal, but as a clinician I understand this default possibly for self-preservation reasons) *No doubt due to the stigma of BPD, alternate diagnosis of Complex Trauma is being used. It will not take long before mental health workers understand this and Complex Trauma will have the same stigma. *The fine balance of not reinforcing negative/manipulative behaviors of the BPD group is acknowledged and understood. "

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?

"Needs Based Suggested Solution: Pilot Program - A place where individuals can be referred to when hospitals cannot support High Risk Individuals. Visit for an extended period (1+ year) Provide a place for individuals to connect with others and learn skills with the focus on meaningful engagement. (as previously defined) This place ideally is a base where patients/users are accommodated fully. The environment is basic (possibly Kibbutz/Moshav-style living) Individual users are assigned jobs to help run the facility as well as meet during meals and group work to support each other. Group expressive therapies; hiking; physical exertion; meditation; mindfulness practice; coping skills; Dialectical Behavior skills etc. covered regularly. Normal appointments and treatment are maintained as needed. Strict behavioral code is to be observed The above suggestion is a rough outline with many issues needing clarification and further exploration. No doubt it will be expensive. As it stands now an individual who has chronic mental illness so often is unable to contribute to society, they will regularly live unfulfilling lives and create a financial drain. If an extended program like the above allows for the individual to transition into society and contribute and live functional lives it will also have financial benefits to tax payers. "

Is there anything else you would like to share with the Royal Commission?

N/A

15 May 2019

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Royal Commission Victoria's Mental Health System

From: [redacted]

As a crisis counsellor I work with a many people from a broad demographic daily. I thus have a great deal of exposure to "the masses" (individuals, family and concerned persons) and based on this I feel that I have some authority to share some of the patterns I have observed as it relates to "The System" and it's deficits. I also have some thoughts about how these deficits can be addressed. I have worked in this field for more than 10 years and in 4 different countries. This I believe also allows me perspective on trends and culture.

Patterns Observed in my role in Victoria currently:

A very large percentage of clients:

… do not experience a sense of connection with anyone. (Some of these clients are socially isolated BUT others are not socially isolated by definition i.e. they live with families but still experience loneliness)

… do not ever or seldom, experience meaningful engagement. Meaningful engagement can take many forms: regular employment; purposeful activities; development of self and others; service to others.

… who present with chronic helplessness, have an attitude of entitlement with little sense of Agency.

… in my opinion, are misdiagnosed with BPD (Borderline Personality Disorder). This diagnosis is more recently presenting with such frequency that it may suggest it is a *'go-to diagnosis' for those who are suicidal and verbalize it. (I have worked with this group (BPD clients) and understand

that the nature of their disagreeableness can be one of a clinician's greatest challenges). *Often by Psychiatrists.

The Deficiencies in the System Observed:

- Not always, but seemingly, the majority of the time, once an individual has been hospitalized for Suicidal Ideation, they are discharged with limited, if not, no support or change in medication or treatment protocol. Individual clients report to feeling a sense abandonment, rejection, helplessness, hopelessness, guilt and shame which of course adds to their risk factors.
- Strong pervasive resistance across the board (nurses, mental health workers, psychologists, counsellors, psychiatrists etc.) to those who are diagnosed with *BPD. (again far from ideal, but as a clinician I understand this default possibly for self-preservation reasons)

*No doubt due to the stigma of BPD, alternate diagnosis of 'Complex Trauma' is being used. It will not take long before mental health workers understand this and 'Complex Trauma' will have the same stigma.

*The fine balance of not reinforcing negative/manipulative behaviors of the BPD group is acknowledged and understood.

Needs Based Suggested Solution:

Pilot Program -

"A 'place' where individuals can be referred to when hospitals cannot support High Risk Individuals.

- Visit for an extended period (1+ year)
- Provide a place for individuals to connect with others and learn skills with the focus on meaningful engagement. (as previously defined)
- This 'place' ideally is a base where patients/users are accommodated fully. The environment is basic (possibly Kibbutz/Moshav-style living)
- Individual users are assigned jobs to help run the facility as well as meet during meals and 'group' work to support each other.
- Group expressive therapies; hiking; physical exertion; meditation; mindfulness practice; coping skills; Dialectical Behavior skills etc. covered regularly.
- Normal appointments and treatment are maintained as needed.
- Strict behavioral code is to be observed

The above suggestion is a rough outline with many issues needing clarification and further exploration. No doubt it will be expensive. As it stands now an individual who has chronic mental illness so often is unable to contribute to society, they will regularly live unfulfilling lives and create a financial drain. If an extended program like the above allows for the individual to transition into society and contribute and live functional lives it will also have financial benefits to tax payers.

I am happy to chat more about the above should you be interested.

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