Our Story:

[redacted]

Our son [redacted] has had mental health issues for about ten years, since the age of twelve. He saw a psychologist, and when he was thrown out his high achievers' program at the end of Year 7, the secondary school refused him access to counselling as it was only there "for people who really needed it". He transferred to another school and their support for him was excellent. [redacted] saw a psychologist at headspace for some weeks in 2011. He started with a private psychiatrist in 2012 and was diagnosed with anxiety and depression. After he contracted infective endocarditis in the same year his psychosis became apparent. On his release from [redacted] he was sent to [redacted] [redacted] at [redacted] Hospital. He then came home under the care of the [redacted] team. [redacted] could be violent and destructive and the police were frequently called. It soon became clear that the police are the first line in responding to acute mental health issues rather than mental health professionals. I know of only one officer of our local station who had appropriate training and he was not always present.

Eventually we took out an intervention order and [redacted] went to live at [redacted] in [redacted]. Although this was a facility for young people with mental health and drug issues, with four staff for sixteen residents, the residents were basically left to their own devices and did not get counselling or programs to help. Moreover, the fact that different hospitals looked after different "catchment areas" meant that [redacted] was shunted from the [redacted] to [redacted], with not much happening in the way of an official handover. He was therefore able to take himself off his medication and no-one enforced his community treatment order.

As [redacted] was unmedicated and unsupervised in the community, his drug-taking escalated, and he ended up, after numerous acute admissions, in [redacted] Hospital, who arranged for him to transfer to [redacted] Parc. On his first day there he took drugs and was expelled at 5.00 p.m. on a Saturday to return to [redacted]. There were no staff at [redacted] on the weekends and no arrangements had been made for his transport from [redacted] to [redacted]. It seemed as though they just wanted to get rid of him as quickly as possible.

At least he had been properly assigned to outpatient care at [redacted], but it was not convenient for either of us to transport him from [redacted] to [redacted] and back on a regular basis, so eventually he was handed over to headspace [redacted], although the team at [redacted] were actually closer to where he lived, in [redacted]. This is another example of where the boundaries work against effective treatment.

Headspace [redacted] did not enforce the community treatment order and [redacted] was unmedicated. His drug-taking again escalated and he was evicted from [redacted]. He was sent to the homeless shelter [redacted]. He was still unmedicated. Headspace again did little except send a case-worker to see him on a regular basis. While there, [redacted] had at least two suicide attempts, and although the police did everything possible to have him admitted to the [redacted] Ward, this did not occur. He finished up in jail and now has a conviction recorded against him. It is our opinion that this could have been avoided if co-ordinated care had been available.

After release from [redacted], [redacted] spent two years at [redacted] in [redacted]. His initial psychiatrist was arrogant and appeared not to have read the case notes, as he put him on a medication that had proved ineffective in the past. In this way, six months was wasted, and it took another two months for another psychiatrist to be assigned. The "programs" at [redacted] were basically ten weeks long, and were constantly rotated, but no effort was made to ensure that patients were motivated to attend. (There is the old joke, "How many psychiatrists does it take to change a light-bulb? One, but the light-bulb has to want to change first.") It was only in the final few months that an OT made a connection with [redacted] and motivated him sufficiently to work in an animal shelter twice a week, wash and wear clean clothes, and take an interest in his health by starting each day with fruit and vegetable smoothies. She moved after ten weeks, and only his volunteer work remained. This appears to be an endemic problem, in that staff who manage to connect with patients move on before anything lasting can be achieved.

My son is now in housing that is clean and that provides acceptable food, but there are no qualified mental health professionals at the facility. His case worker, or some other staff member of the Mobile Support Team at the [redacted], used to see him on a regular basis to administer his medication, but this now been handed over to the staff at the residence to administer. The residents are largely left to themselves, and frequently manage to get around prohibitions on the use of illicit drugs and alcohol.

[redacted] has continuing drug problems and is frequently admitted to the [redacted] Emergency department, at one stage at the rate of twice a week. He is seeing a drug counsellor for one or two hours a week and he is on a long list to be admitted to the only dual-diagnosis centre in Melbourne. Nothing can be done until [redacted] gets a second opinion from Borderline Personality Disorder specialists with another waiting list of 4-8 weeks. In the meantime, his drug use may possibly get him evicted from his current residence. He will then be homeless.

Based on our experience, we suggest the following:

1. Police should not be the default first-line responders.
2. Mental health services need to be co-ordinated. Splitting between areas does not always lead to more efficiency. Things do not always get passed on between agencies.
3. More staff continuity is needed. Far too often, when a client finds a staff member to relate to, they are moved on or apply for promotion or another position. Qualifications here are less important for the client than relatability and stability.
4. Carrying on from the need for continuity, secure housing with specialist staff availability is needed.
5. Better and more specialized drug rehabilitation is needed for people with acute mental illness. There is a disconnect between mental health services and drug-rehabilitation services. Mental health services claim that medication has stabilizes the patient and that it is not part of their remit to treat the drug addiction, while drug-rehabilitation services claim that the problem is psychiatric and treatment is therefore not part of their responsibility.
6. The NDIS needs to be reformed so that it is more navigable and more funds need to be available to support carers. There also seems to be a reduction in the useful services performed by the State government due to its introduction.

PERSONAL DETAILS

My name is [redacted]

Qualifications:

I hold a Bachelors of Arts (Psychology) and Nursing (Monash); post-graduate certification in Psychiatric Nursing Practice (Royal Melbourne Institute of Technology (RMIT)).

Brief Summary - Professional Experience:

I am a Mental Health Clinician registered with the Australian Health Practitioners Regulation Agency (AHPRA).

I have been employed by the Victorian Institute of Forensic Mental Health (VIFMH), since 1999.

I have twenty years' experience in the forensic mental health system in diverse roles, including:

1. Magistrates' Court of Victoria – conducting independent and impartial clinical assessments;
2. Thomas Embling Hospital (secure inpatient) – primary nursing (acute care; recovery);
3. Community Forensic Mental Health Service (CFMHS) – case management of persons afflicted with serious mental health issues at risk of offending.

DISCLOSURE STATEMENT

The current submission is made in a personal capacity: all views and opinions are my own.

Public sector employees are subject to encumbrances in submitting information to the Royal Commission.

Human Rights are universal and briefly, include:

1. *Charter of Human Rights and Responsibilities Act 2006 (Victoria);*
2. *International Covenant on Civil and Political Rights (ICCPR) to which Australia is signatory:*
    a. *Freedom of thought... (ICCPR Article 18)*
    b. *Freedom of information, opinion and expression (ICCPR Article 19)*
    c. *Right to take part in public affairs, voting rights and access to public service (ICCPR Article 25)*
    d. *Rights to equality and non-discrimination (ICCPR Article 2.1, 26).*

KEY CONSIDERATIONS FOR THE ROYAL COMMISSION

SOCIAL POLICY and REGULATION

Mental health services are both part of and interface with a range of social institutions and there must be policy coherence with attention to complexity in social systems - in order to support optimal outcomes in peoples' lives.

People are exposed and subject to social policies (schools, universities, workplaces....) and governed by regulations.

In my experience, policy and regulatory agents need to direct greater care and precision in formulating social policy with attention to the impacts and possible unintended consequences (negative additive effects), longitudinally - throughout peoples' lives.

Policies and regulations should support peoples' current and future rights to self-determination, promoting: physical, social and mental wellbeing; thereby, supporting inclusion, participation and optimal outcomes.

A. Educational Institutions / Universities

In the tertiary education sector, access to support to successfully complete education may have far-reaching consequences across the life-span and subsequent opportunities and quality of life – this includes, social opportunities.

Key Recommendation:

- This means that greater emphasis and support needs to be directed to student housing/ accommodation, financial support – and real and meaningful opportunities for social inclusion and participation in educational institutions.

B. Risk Assessment and Management

It is frequently noted to the effect that interventions should be: "...early...at the right time, in the right place and in the right mode...."

Key Recommendation:

- Interventions to support and assist people need to be: evidence-based, strategically delivered and titrated to individual needs and circumstances.
- There should be standardised approaches to assessment and interventions that factor in critical periods of social development across the life-span and optimal outcomes which create real opportunities for self-determination.
- This necessitates addressing peoples' needs within a bio-psychosocial approach and with attention to intergenerational issues, including - any risks for the transmission of intergenerational stressors and trauma.

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Organisation Name
N/A

Name
Anonymous 42

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?
N/A

What can be done now to prepare for changes to Victorias mental health system and

support improvements to last?
N/A

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