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

SUB.0002.0006.0096

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
Public awareness campaigns on television and social media. Challenging and shutting down negative stereotypes. Support services in the workplace for people who experience mental illness.

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?
Community service providers in the mental health area do great work in preventing and managing serious mental illness. Public services however require significant improvements.

What is already working well and what can be done better to prevent suicide?
Please see attached written comments

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.
"Living in a regional and rural area, the public mental health services are very difficult to access. Please see attached written submission for information."

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
"Financial stress, lack of employment opportunities, work related stress, relationship stress, family breakdown, droughts and other environmental issues, negative stereotyping on television and social media which extends into the community."

What are the needs of family members and carers and what can be done better to support them?
See attached submission

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?
"I can honestly say that in a rural and regional area there is very little opportunity and that the chances of improving this have gotten much worse since the introduction of the NDIS. Moderately

unwell people, who are the most likely to gain benefits through community engagement are the ones falling through the gaps and not eligible for NDIS support. "

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?
see attached submission which contains multiple suggestions.

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

Royal Commission into Victoria's Mental Health System

I am making this submission as someone who has cared for a person with a serious mental illness and who has experienced the mental health system from this perspective. I am also making this submission as a worker in a community services organisation who has worked with clients who have a dual diagnosis mental illness and substance use issue. I addition, I live and work in a country town with very limited access to mental health support and so I am writing with a rural perspective in mind.

In all of these roles I have experienced significant issues with the current mental health system in Victoria, which I will outline first. Once I have outlined the issues I have experienced or witnessed on behalf of my clients and family members, I will then provide some feedback about possible solutions to address them.

Issues with the current system:

1. There are significant problems in the rural area in being able to access mental health services. Unless a person is experiencing psychosis, public psychiatric services will only accept referral based on extremely limiting criteria. Even when a person is experiencing a psychosis, I have had workers reject referrals because of a dual diagnosis substance use issue. I have frequently found that the local psychiatric service will reject referrals from local health services and instead suggest private psychiatric services. In most cases these are almost impossible to access because of our regional setting. For example, I have been working with a client who has been diagnosed with bi-polar disorder and told that the client should see a private psychiatrist for review because they didn't agree with the diagnosis, stating "it's probably a personality disorder". The waitlist for a private psychiatrist in our region is at least 6 months, unless the client is supported to access services several hours away. It seems to me that the local psychiatric services will reject a referral until the client reaches crisis point and enters their service because they are admitted via hospital or police intervention.
2. City workers have often asked me about accessing our local CAT team. We don't have a CAT team. If a person is in crisis, we only have access to an after-hours service which is located several hours away via phone. If they believe a person requires immediate attention, the client is referred to our local hospital, which is staffed with a skeleton crew of nurses who are not adequately trained to deal with mental health issues. When attending the hospital after hours with my family member, they appeared fearful, unable to cope and would sometimes call the police. Their solution was to sedate my family member and put us in a room where we were ignored for hours. Sometimes an on-call worker would arrive, sometimes we didn't see anyone until the next day. This is pretty unpleasant when someone is experiencing psychosis.
3. The attitudes of too many of the public psychiatric staff is appallingly negative towards the clients and their family and friends and even their support workers. For example, on one occasion I contacted them for a secondary consultation about a client and the worker stated: "Why are you working with him? He doesn't deserve a service". I find this attitude offensive as a worker and can only imagine how the client would have felt had they known that this was the attitude of the local mental health provider. The worker in this case again denied a previous diagnosis, asserting that the client had a personality disorder. Unfortunately, this attitude and behaviour is a common occurrence. On another occasion a worker laughed at me for calling and asking for a secondary consultation about another client with a dual diagnosis, clearly unwilling to even discuss their psychotic presentation. I have left voicemail messages for workers to contact me about clients many times and

received no reply. The general lack of respect and courtesy is quite appalling. Clients with significant personality disorders are dismissed, treated as though they are just attention seeking and rejected by public psychiatric services. They will often reject referrals solely on the basis that they believe a client has a personality disorder without doing any assessment and even if the client has previously been diagnosed with other mental health issues. It seems that unless you can throw a pill at it, the public psychiatric service doesn't want to know about it.

4. I am aware that there is supposed to be a "no wrong door" policy for clients who come through mental health services with a dual diagnosis, but this is definitely not the case. Public psychiatric services rarely work with clients who have a dual diagnosis and frequently refer them to alcohol and drug services who try to manage both conditions with extremely limited resources and receive little or no support from other services.
5. Suicidal patients are not taken seriously in the majority of cases, are not well assessed and are referred back to the community sector, which again seems to be based on snap judgements about personality issues.
6. Clients who have accessed psychiatric services or been admitted to the Acute Psychiatric Unit have gotten worse rather than gotten better. I had a client who was admitted involuntarily during a severe psychotic episode and was removed after five days by his carer because he was getting worse and was being treated with disrespect by workers in the unit. I encouraged this family to submit a complaint, which they did. It is pretty appalling that a client can access a service that is supposed to help them but instead come out worse off. I have unfortunately had the same feedback from multiple clients.
7. Lack of support available for clients who have trauma related mental illness such as PTSD. There is inadequate public, non-government community and private services available throughout the entire rural/regional area for anyone to receive appropriate care and treatment.
8. While caring for someone with a mental illness, I found the local public psychiatric services to be unreliable. They would make appointments and then cancel them at the last minute. They would often not turn up without warning. They would promise to do things and not follow through. They would say they were going to call and not call. While the workers themselves were obviously overloaded and appeared worn out, this is not good practice. In addition, I felt that the information and education that they provided following diagnosis was extremely inadequate to assist my family member in understanding and managing their illness. If I were not there as carer and capable of researching this myself, we would have been left floundering. They only stepped in during a crisis and when the real work needed to be done, it was all left to the family. There was no support to access carer support services and no assistance to help my family member remain well.
9. There is a lack of support for carers who carry the greatest burden of care for people with a mental illness. These services seem to have totally disappeared with the introduction of the NDIS.
10. Community service providers are left to pick up everyone who is rejected by the public services. In my opinion, they provide a significantly better service to clients from my experience as both a worker and a carer. These services display greater care, take the time, provide the follow through clients need and support clients to manage their mental health. The recent changes to mental health as a result of the NDIS has been a nightmare, with services disappearing or changing so that once again the criteria to access support is so narrow that too many people miss out. This has created a huge gap in support.

11. The NDIS usually rejects clients with a dual diagnosis. Mental health issues are often blamed on substance use and so a client with substance use will not meet the criteria of permanent disability. These clients often use substances because of their mental health and so are unfairly disadvantaged.
12. The NDIS provides support based on when a person is unwell, however mental health is an episodic illness. Providing support while a person is well is essential to a person remaining well. I do not believe therefore that NDIS is the solution for people whose illness is episodic or who is moderately unwell.
13. There is a significant lack of private psychiatrists and psychologists in our region and any who do come to our region generally move on after six or twelve month stays.

After thinking long and hard about what needs to be done to address the concerns of my clients, my family and my community, I have come up with a number of ideas which would significantly improve the current provision of mental health services in our region.

1. The establishment of a specialist personality disorder unit within all public psychiatric services, which includes workers who are trained in best practice models such as Dialectical Behaviour Therapy, Mentalization Therapy, Schema Therapy etc. This service should include psychologists qualified to diagnose significant personality disorders, as well as care co-ordinators who can work closely with non-government community services for the treatment and benefit of clients. In doing so, public mental health will no longer be able to dismiss clients without adequate assessment. And, I hope that people with personality disorders will be treated with the dignity and respect they deserve, instead of labelled as troublemakers not deserving of support.
2. The establishment of specialist dual diagnosis services based within public psychiatric services who will provide dedicated support to clients with substance use. Their role will include supporting clients to link in with drug and alcohol services. They will work closely with AOD services and provide a shared care planning approach to address the mental health and substance use issues. In establishing this unit, the public mental health service will be held accountable for including dual diagnosis clients instead of continuing to exclude them.
3. Provision of dedicated mental health trained nurses or social workers based in regional hospitals who can provide timely after-hours support to patients attending for mental health issues. This role would include care co-ordination to ensure that follow up support is arranged.
4. The establishment of a specialist intake workers in public psychiatric services who will provide dedicated support to clients and families who contact with concerns about suicide. The worker would be required to complete a risk assessment and safety plan immediately, in a similar fashion to the family violence sector. After initial contact, the intake worker would refer to either the public or non-government community sector to ensure that the client is provided with ongoing care and support.
5. There needs to be significant investment in training and support for current public mental health services and the opportunity to improve their performance. This should be measured through mechanisms for providing meaningful feedback from clients, carers, stakeholders, non-government community services and private providers.
6. Significant investment in funding and training for non-government community sector providers in outlying regional areas so that they can increase their capacity to work with moderately unwell clients. This needs to include specific areas such as dual diagnosis, personality disorders and clients with co-morbid conditions.

7. Significant investment in funding and training to the non-government community sector and private providers so that they can provide specialist care to people who have experienced trauma and/or who have a diagnosis of PTSD.
8. Increased funding and a broadening of the criteria for people to access community service programs which were previously provided through the Personal Helpers and Mentors and Partners In Recovery programs, so that anyone seeking support can be eligible without having to meet NDIS requirements.
9. Increased funding for community engagement activities which are not related to NDIS.
10. Provision of support and funding to assist carers in understanding and managing the mental health of their family members, including improved access to respite. This could be through a specific carer support service or may be provided through non-government community services.
11. Incentives which encourage private psychiatrists and psychologists to practice **long term** in rural and regional areas.

While it is apparent that there are a lot of issues in the mental health arena, I have come to the conclusion after years of dealing with the local psychiatric services, that the biggest issue in mental health is the entrenched negative attitudes and performance of the majority of workers at the public psychiatric services. It is likely that this has developed as a result of being overworked, understaffed and poorly supervised, however this does not justify the major flaw within the sector. While this continues, there will never be an improvement in the quality of care to the people in the Grampians and Wimmera region and I suspect, throughout the State of Victoria. Only with a new wave of approaches, which cross all areas of public need, is there likely to be improvement. That is why my suggestions cover a broad range of public services, the non-government community sector and private providers. It is only through a multifaceted approach that we can begin to address the issues.