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

SUB. 0002.0001.0033

Name
Anonymous

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
The idea that suicide is 'attention seeking' behaviour needs to be removed from the way staff in the Mental Health Industry operate.

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?
I don't believe people who need support with their Mental Illness will have the ability to seek the appropriate help themselves based on my experience. The System needs to allow family / friends to advocate for individuals who need support and to really listen and take concerns seriously.

What is already working well and what can be done better to prevent suicide?
"My brother was able to suicide whilst in Adult Acute Unit care at [redacted] Health Services in 2015. [redacted]. In summary her major findings contributing to my brothers death were1. Safety of the environment - hooks were installed into the ensuite door which were unsafe and allowed my brother to hang himself.2. Nursing observations were inconsistent between the records and the CCTV footage and were not of the required quality. [redacted] should have been observed at 15 minute intervals however in the hour leading to him being found, he was only observed twice; for one and two seconds respectively with the nurse peeking through a gap in the door. Gaps were noted of up to 43 minutes on the night [redacted] suicided. There are many more issues uncovered through the Inquest which I believe would be of interest to the Royal Commission so I please encourage for the full document to be reviewed. "

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.
Being turned away or made to feel like they are attention seeking.

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
"Not enough resources. Being turned away when support is required. Not being listened to, or taken seriously"

What are the needs of family members and carers and what can be done better to support them?
To be taken seriously. To be heard and listened to with empathy. To be kept updated

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
Toxic work culture has no doubt been an issue well publicised at [redacted] Health Services for a number of years. I do not know why there is a toxic work culture or how it could be improved.

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?
SafetyQuality of workAudits of environment to be regulated and monitored by a government bodySharing of information found from Coroners Inquests. It is heartbreaking to know there are other families who have lost loved ones due to hanging using the same hooks in ensuites which my brother had access to. This should never have reoccurred after the first time it happened

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?
"My brothers death has deeply impacted my Parents and has forever changed my future as he was my only sibling. His death could have been avoided as was found in the Coronial Inquest.Throughout the Coronial process we felt [redacted] were not held accountable for what happened while [redacted] was under their care and we hope that through the Royal Commission these issues can be reviewed and addressed and recommendations be put in place to truly avoid this happening to another family.Additional Note: After my brothers death I raised two complaints with the Mental Health Complaints Commissioner. One on behalf of [redacted] (Deceased). The other on behalf of my Dad who received care after my brothers death due to having his own Mental Health issues related to the loss of his son. The file for my brother remains open with the Complaints Commissioner as far as I know. This is another avenue which could potentially be improved. I felt the case managers at the MHCC changed very frequently and I never received any closure from following this process. To this day my question to the MHCC has been around the ramifications to the nurses on shift during the night my brother suicided. Once it came out that they lied about performing 15 minute observations due to the CCTV footage, did they lose their jobs? What was the impact to them? I feel there is no one to go to about this issue. Is that something the Royal Commission can address as a recommendation? "