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

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N/A

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What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"I have had the benefit of coordinating or undertaking several community consultations in the past 18 years of being a Victorian resident. While there is significant stigma about illness there is very little stigma about stress which is seen as universal. Exploring stress and its underlying impact of all health conditions is an acceptable entry point into discussions about illness. These discussions cluster mental illness with the range of physical health issues. Stigma is based on perceptions of judgement - of the ""shoulds"" in life. In a world of rapid change, teaching our children at the youngest developmentally applicable time point about resilience and the mechanism of cognitive restructure will be beneficial to the removal of stigma. Recommendation 1 - Adopt a population based approach and whole of intervention approach to planning and delivery of services. Relabelling the services to redress stigma. Rationale: Mental Health is much more than mental illness yet the two are confused by the community. We need to make mental health be seen as a desirable and essential thing to individuals, families and communities. No other service has a greater investment in this than our state funded services. As an individual I would suggest that Victorian public mental health services be relabelled Mental Health Wellness and Mental Illness Recovery Services to denote the dual mission of the services. "

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?
"A broad based mental health literacy program based in local libraries and community centres matched with MHFA education has worked very well over the course of the last few years. Interventions in schools as early as possible focussed on prevention but complimented by early intervention programs has been highly successful as they have been implemented in collaboration with DEECD at regional level. 2. The implementation of prevention programs targeting at risk populations who are socially isolated or marginalised in partnership with other agencies e.g. drug and alcohol services and family violence services. 3. The development and implementation of an at risk protocol for people who are at heightened risk of developing a mental illness. This needs to be delivered in partnership with GPs and other primary health care providers and would involve a public surveillance mechanisms (like those employed for other health traumas), data mining of CMI (or it's replacement) to determine children, VEMD, VINAH and VADC. "

What is already working well and what can be done better to prevent suicide?
Focusing on the outcome of suicide from a prevention stance in my perspective is without merit. If it was with merit the we would have seen a reduction the suicide rate already given the significant investment made by government to date. We need to as a community understand the despair that leads people to make this choice and what causes the despair. It is the cause of the despair that needs targeting.

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.

Please see note on stigma about confusion between mental health and mental illness. This question itself represents this confusion. Good mental health as stated needs to be encouraged and the techniques individuals can apply and be responsible for need to be taught.

Recommendation: A single public health campaign targeted to the general community that teaches them how to maintain their good mental health. Please see 5waystowellbeing.org.au as a recommendation for evidence based campaign. 5ways is an evidenced based campaign from the UK that has been customised to the Victorian public through extensive consultations.

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

"The social determinants of mental health need to be recognised as factors as a community we can influence. In our consultations our community prioritises social isolation above access to economic resources and freedom from violence and discrimination. Programs such as Connect4Wellbeing redress social isolation by connecting with people at their front door. Connect4Wellbeing is currently working with property developers to encourage social connections between neigbours as part of place based design. Previously work done in the secondary schools to examine the violence in interpersonal relationships and re-educate, practice and review change has been very beneficial to young people. It also saw a reduction in the referral rate from these schools to our whole of life service. We can't underestimate the impact that a lack of purpose for one's life has on their psyche and on those around them. In a changing society where having a gig rather than ongoing employment is becoming the norm I believe the benefits of volunteering can not be under promoted. This however shouldn't with a cost to the individual. From clinical, service demand perspective I can not over emphasise the impact that substances, particularly Methamphetamine has had on communities. It ravages the lives of the user, their families, creates risk for clinicians and leads to admissions that rob the person of their dignity."

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

"Recommendation: family orientation and family psychoeducation program about specific illnesses, treatment. Families and carers are individuals and not one size fits all however information available across multiple communication channels appears to be universal. Services do need to consider being available outside of business hours for the personal contact needed to build trust and rapport."

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

"In the past 10-12 years the privatisation of the workforce through the medicare items has meant that there are many options for clinical staff who have specialist skills. Attracting staff to work in a lower socio-economic area where crimes against persons are statistically high is proving challenging particularly senior staff. It has become apparent that there is less experienced staff working with higher acuity in the community than the earlier part of my career. As a manager/leader of a team, all I can do is promote a supportive, progressive and flexible working environment along with excellent professional development opportunities. Peer workers, alternative therapists and community development workers are a different category of staff to

clinicians. Requiring a direct pathway to me with regular out of hour communication initiated both ways ensures that creativity is supported, conflict with clinicians is addressed ealry and most importantly that their exposure to being triggered or re-traumatised is reduced. Recommendation: Place consumer and carer peer workers at points in the continuum of care that represent the lowest point of personal control for consumers and families. Embedding a consumer peer worker into the acute community function to act as a concierge at the time of people's greatest distress has proven to reduce the reported trauma and distress consumers experience. Having someone who has lived the experience you are about to endure, who can not only offer reassurance about the experience but about the clinicians involved in the experience is well worth replicating. Recommendation: Create another specialist/alternative team for peer workers to be included into. Our peer workers report feeling that they are part of a team, not just the clinical team but of the 'alternative' team. "

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?

"Recommendation: Put aside the fact that the person/people have a mental illness and facilitate connections based on common strengths and needs. Our consumers told us in the last year's YES survey that we were doing nearly always or always the right things, however they still didn't have hope for themselves and their well being wasn't great. It was apparent that the answers about what could be done lay with the consumers themselves. A letter inviting participation in a focus group (or groups as it turned out) revealed that again that consumers wanted more social connections. Subsequently a group of consumers, along with one peer worker and community development worker is working up a response which we have tentatively labelled the Friendship Circle. "

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?

"We need to refocus on the needs of people with a mental illness and get treatment to them as early as possible in the course of their illness or individual episode. We must accept that mainstreaming has largely been a failure. We must acknowledge that the life expectancy for people with a serious mental illness is dramatically reduced. Recommendation: Option A - create integrative health care hubs across all catchments that includes specialist mental health teams, GPs, pathology, radiology along with visiting cardiac and cancer specialists. Option B - call for expressions of interest from local GPs to partner with local public mental health services including psychiatric disability support workers to work together to service (a) GP patients who are considered at extreme risk of development or relapse of a mental illness (where mental health service would provide specialist interventions and (b) public mental health consumers (where GP would provide generalist physical health interventions). Vision - 5 GPs matched to 5 dedicated clinical teams. Once day per week service for each team/GP configuration, starting with intake meeting that plans the work a fortnight in advance inclusive of contingency planning. The impact of substance use on the development of psychosis or psychotic break must be addressed. Recommendation: Develop a media campaign (inclusive of social media) akin to the AIDS campaign of the mid 1980s that shocks the public into awareness that the use of Methamphetamine (and others) in approximately 40% users results in psychosis. It should show the deterioration process, inclusive of an involuntary admission with seclusion/violence etc. Recommendation: Introduce long stay beds as part of a planned recovery/rehabilitation program

that focusses on skill development/enhancement, psychoeducation, psychological, alternative and occupational therapy and has a graduated and planned return to community program. The need for aslyum still exists well past deinstitutionalisation. Victoria is the only state to totally de-institutionalise and while this was innovative at the time, it has resulted in a number of people occupying costly acute beds while not necessarily having their recovery needs met. Recommendation: Acceptance that some consumers will always need to be engaged with public mental health services due to severity of illness and/or risk. Develop rehabilitation program for this group of people which focusses on physical and social activity alongside psychological interventions such as cognitive remediation and socog therapies. "

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

"Recommendation: Reduce waste in the system. Maximise the time clinicians have to provide care. How: Reduce the number of handovers required to coordinate care by reconfiguring our shifts so that we are never turning over 100% of our staffing group at one time. This will be supported by defining the coordination roles of senior staff. How: Introduction of voice activated mobile technology to reduce the administrative burden for clinicians. The administrative burden for clinicians runs around 50% of their time. Then we ask them to stat their time! CMI facilitates the duplication more so now than ever before because of the lack of middle wear that allow for communication between it and the evolving EMRs. Recommendation: Adopt, train and roll out a whole of government Recovery Approach that is matched to clinical interventions at each stage of Recovery. This could be the psychological recovery model. Regardless of what the model is consumers and their families have a right to know what stage of recovery the consumer is in, what menu of interventions are indicated in the stage so they can and the MH system can share in some expectations/common ground. What is delivered shouldn't vary at its core across the state. "

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

"Our mental health system is in a state of despair. It doesn't seem to know what its mission is - do we teach people how to have good mental health, do we prevent, do we intervene early, do we treat and if so how or are we just churning people through beds? On any given day we hear and receive into community care people who have been discharged from hospital not because their mental state is better than at the time of admission but because there is someone else probably slightly worse or significantly worse than them in the community that the bed is needed for. We then have to report on readmission rates! It is clear that we can't continue on this cycle of the squeaky wheel gets the oil, i.e. you need to be acuity unwell to get services. We must look at being truly bio,psycho-social in our approach from the earliest possible time in a person's life based on their individual risk and protective factors. We have as much of a role as a community is bolstering the range of protective factors for good mental health and we have of preventing and managing the risks of mental illness. Victoria was a state regarded across the country as being a leader in mental health when I moved from my home state of Queensland in 2001. Coming into a position that developed the community mental health plan based on population needs, characteristics and challenges was visionary. Blending health promotion, prevention, early intervention,evidenced based treatment/interventions was without doubt ahead of its time but I fear over the course of this century thus far, the way has been lost. I like so many other health professionals believe the path can be corrected but we must rely on the wisdom of the collective and finally empower those with the knowledge - our consumers and carers. Thanks for the

opportunity to personally contribute to the commission. Please note that all content represents my own personal insights and opinions. The recommendations contained herein in no way represent the views of my employer, professional association or any other associates."