Victorian Royal Commission into Mental Health – De-identified Case Studies

Case Study 1

Jane Jones is a [redacted] year old female who lives alone [redacted] She has a diagnosis of severe depression and anxiety. Jane has been receiving MHCSS funding since [redacted] and before this was with the Halcyon Day Program and PHAMS (personal helpers and mentors)) since [redacted] She was regularly receiving weekly 1:1 support with a support worker and attending weekly walking group, art group and women's group. She felt well supported and always had a support worker, peer worker or team leader available to discuss her mental health issues and receive support when needed. Under the NDIS Jane mental health has deteriorated and she has disengaged from services by refusing to work with allocated support workers. She has had hospital admissions and PARC admissions this year as well as receiving case management from Eastern Health.

Jane has stated that she want to go back in to PARC regularly as she feels supported at the facility. She has been told that there is a 3 month wait. On the [redacted] Jane had messaged a peer and stated that "she was lost and was going to die. " Staff tried to call her but she would not answer her phone. Staff called Police and Mental Health Triage to report to them of the incident. Staff drove around to her house and were able to gain access to the house without breaking in as her neighbour had a key due to ongoing issues with Jane. Jane finally messaged back to staff and stated she was out shopping and that she was fine. Staff let her know that they had to act on the conversation that she had and that they had to do a welfare check. This is not the first time that this has happened. There was another incident at the beginning of the year where Jane was found hiding in the neighbour's garden. She was then taken to hospital. With no support worker being able to step in and out when needed for Jane she is falling through the gaps and needs regular clinical support to become well. She has not been taking her medication regularly and needs constant reminding to do this. Clinical services are under pressure and are unable to offer the flexible support that Jane requires to maintain her Mental Health.

Case study 2

Jim Smith is a [redacted] year old male with Psychosis and Dissociative Identity disorder. He lives independently with his dog [redacted] and works part time in the disability sector when he is well. Before the NDIS he was receiving adequate Mental Health Services from EACH under the MHCSS funding model. He could attend groups, have weekly 1:1 support and also call in to the office and speak with peer workers, support workers and team leaders if needed as he became unwell periodically. During this time he had a 10 year period of functioning well in society and staying well, holding down a job and maintaining his housing. He could attend PARC for respite when he needed to and did not have to be clinically case managed for this to happen but with all the changes to admission criteria he is not able to access this anymore. He regularly sees his psychologist and psychiatrist but due to the MHCSS funding ceasing and our group centre Halcyon closing, Jim mental health symptoms have increased. Halcyon was a place of respite and familiarity for Jim and many other consumers. His voices/identities remained calm and allowed him to function without tormenting him or punishing him for being well. He had friends and staff who were familiar with him and understood what he was going through.

Since the ceasing of MHCSS services and the transition to the NDIS, Jim has deteriorated in his mental health and his voices have become more aggressive and telling him constantly to end his life. Due to the voices he has not been able to work and this has had a flow on affect to the point where he has had to see EACH Financial Counselling Services due to increasing debts and cost of living.

Jim received a good package for his first NDIS plan in [redacted] *but with his deterioration of mental health was not able to access services as his support workers, that he had built trust and rapport with, had moved on to other roles due to lack of funding in the NDIS. He was quoted on groups and 1:1 support but only attended a handful of times due to being so unwell. His new plan came through last week where it was cut drastically from $60,000 in the first year to $38,000 in the second year.*

Due to the NDIS being rolled out Jim has deteriorated in his mental health and does not have the weekly supports he requires. He is not able to access appropriate and adequately trained staff who he has a rapport and relationship with. He has attended an external local drop in centre at Mooroolbark who have hired peer workers. Jim stated that these peer workers are still unwell themselves and are not able to offer him support as they are currently working through their own issues. Also the other staff at the drop in centre are always too busy to talk. He is weighing up whether it is worth continuing with this. Jim stated he does not know what to spend his money on in the NDIS and is happy to pay more for experienced and reliable staff but does not know where to find them.

Case Study 3

"For the past 15 years my wife has lived with an acute psychiatric illness. This has seen her admitted to hospital several times, with the usual length of stay being 5 weeks. My role is both as husband and carer, and I also work full time in order to support us both. The stresses of caring are very high, which places a burden on our relationship and my own health.

My provision of care reduces admissions, helps with medication compliance, and assists with post admission recovery and overall stability. The cost savings to the Government are substantial due to this involvement in my wife's care. The best outcomes are when we work as a team with myself as the main carer, and when other services and support people are involved. For ten years we have utilized many of the psycho social services provided by EACH which are an integral part of the team keeping us both as well as possible.

There was one time my wife had become quite unwell while on a group walk with EACH consumers and a MHCSS support worker. The worker was able to recognize my wife had deteriorated and had considered calling emergency services or Triage. However her experience in the mental health space enabled her to take another course of action. The worker decided to take my wife home and place her into bed. The worker also knew how to de-escalate the situation by providing my wife with sensory objects that could calm her. When stabilized the worker called me and I quickly returned home from work to assist. After a few days of rest my wife recovered and we prevented another admission to hospital.

There is no doubt in my mind that a less experienced person would have called emergency services and my wife would have been admitted. Every time my wife is admitted her condition becomes much worse due to the nature of hospital environments. Knowing how to provide support and care is critical for carers and support staff. Without this skill base consumers and family members will be put at risk. The NDIS funding does not pay enough to retain highly skilled support staff and I believe this will be of detriment to my wife and myself.

A Mental illness is not a choice, just like having a disability is not a choice mental health Issues can be just as debilitating as a disability, believe me I live with both, and if you have never suffer from a mental illness or disability you will never understand, the huge impact it can have on your life, until it happens to you, So please don't think you know what's best and just give a tick or a cross when

assessing my NDIS plan understand I need this Service provider in my NDIS plan for my health and wellbeing."

Case Study 4

Client A suffers from severe schizophrenia and is plagued with negative voices. He manages this with medication and strictly limited activity. Leaving the home increases the negative voices and is sometimes unbearable. Client A's house is extremely dirty because cleaning triggers the negative voices. He can manage only one activity per day.

I assist Client A to regularly visit the GP and attend specialist appointments. I take notes and provide written records to him. I also prompt Client A to follow through with treatment for a complicated health issue. After many years of building a trusted professional relationship, Client A consented to have me assist him clean the bathroom and to support him to visit a city based health specialist. Client A requires a great deal of gentle persistence to deal with everyday tasks and appreciates the personal support provided by a specialist mental health worker who understands his mental health condition and will provide assertive support.

I'm concerned that when Client A loses the support of a consistent specialist mental health worker that he will find it too difficult to engage with supports because the various unskilled workers may not all understand his special needs. I'm concerned that Client A may thus have more hospital admissions and eventually lose his independence.

Case Study 5

The pricing structure has made it incredibly difficult for mental health support to be managed in accordance with an individual's needs. Where a generic support worker role can work with an individual during periods where they are largely well, there is no provision made for more specialized support in times of crisis. This is illustrated by the following customer case study.

PC is a [redacted] year old divorced male with paranoid schizophrenia living in a bungalow on his daughter's property. PC suffers with constant auditory hallucinations of several unknown voices telling him to kill himself. He finds this extremely difficult to manage and as a result has had several hospital admissions in recent months. PC is very high functioning having been an AOD counsellor for many years and also working for many years for Child Protection with these symptoms active.

PC has been accepted for NDIS- this unfortunately makes him ineligible for any of the available mental health options. He has been referred to a NDIS approved Social worker – but she has little concept of mental illness and especially psychosis.

NDIS does not cover the cost of Psychiatrists - there are very few bulk billing psychiatrists and many charge several hundred dollars above the gap fee per visit. The need for a psychiatrist was minimal as the GP was able to liaise with the mental health nurse in relation to medication options, hospitalization, etc. This will now not be an option for PC who is on a DSP and will not be able to afford this.

PC's daughter is fearful that her father will avoid going to see a Psychiatrist because of the cost and that he will become increasingly difficult for her to manage.

Case Study 6

"My name is....
I have significant mental health issues, Generalised anxiety disorder, post-traumatic stress disorder, depression which got that bad it unfortunately lead to psychotic depression, my depression must be closely monitored along with the rest of my mental health Issues.

My mental health has a major impact on my life on a day to day basis and can be extremely challenging to deal with and debilitating for me.

My mental health issues do not just disappear. Because I take medications and my issues are lifelong conditions that affect me on a day to day basis, it is paramount for me to get support. Following several psychotic episodes, I was connected to Community Mental Health clinic for several months and since my discharge have been supported by my Community Mental Health worker. Having a Mental Health support worker to visit me a few hours a week would greatly improve my mental health as I could have someone to support me that has fresh eyes different insights, Suggestions and having a community service worker give me lots strategies and techniques to use and an ear to listen, would help me as this also takes pressure off my relationships with family and friends.

To be able to be involved with programs run by this organisation to help with my mental health would be a significant Improvement in my life as this would give me an opportunity to interact with other people that have mental health issues which in turn then means that I do not feel as isolated within my community.

To not have this support from this Organisation would significantly disadvantage me in the community, by isolating me. "