Royal Commission into
Victoria's Mental Health System

# WITNESS STATEMENT OF SANDY JEFFS OAM

I, Sandy Jeffs OAM, say as follows:

## My background and early years

1 I describe myself as a relic from Larundel (Larundel Psychiatry Hospital). I was diagnosed with schizophrenia in 1976 when I was 23 years old – what feels like a thousand years ago. At the time, it was like a death sentence to have that diagnosis because of the pessimism around it, which was so extreme at the time. A diagnosis of schizophrenia was seen as a relentless journey into madness from which one would never recover. There was no notion of recovery, no presumption of capacity; you were on the scrap heap. I went from being a promising student to a mental health patient on an invalid pension. So the trajectory was a downward spiralling one, socially and in all other ways.

2 At this time of my life, I was supposed to be getting into life, getting a job and a career and all those aspirational things you do at that age, but it all came to crashing halt because I became a mental patient – a 'psych patient'. For six years of my so-called psychotic life, I was in and out of Larundel quite a bit. From memory, between 1978 and 1984, I had six admissions. I had my last admission in 1991. It was a tough time because I thought my life had come to a crashing halt. I thought, '*Do I go and top myself now and get it over and done with, because I'm just going to be a burden on people*'? And that life – as a psych patient – was going nowhere in terms of positivity, or in terms of having purpose and meaning in my life. I had lost all my hope, purpose and meaning. I lost a reason to get out of bed.

3 These were grim times. I don't know how I survived those years. I had really chronic years between 1978 and 1991 where I didn't do much in my life. I was withdrawn as a person. I was shy, unassuming, had no opinions, and I was too scared to be forceful. I was a wallflower who nobody noticed for many, many years. And it was tough work.

## Larundel

4 At Larundel, I had time and space in which to form a therapeutic alliance with nurses. I had some great nursing at Larundel because their whole working notion was to get out into the wards and spend time with the patients – which is what happened.

5 Larundel had beautiful gardens that you could walk around in and find solitude and peace. It was a different time, obviously, but I had good experiences of some really good healing nursing in those times.

6 In my view, an ideal therapeutic relationship with a nurse involves spending time with the patient to get to know them, and offering support and comfort. Back in the Larundel days, a lot of the nurses spent quality time with patients. I had nurses taking the time to get to know me as a person and spend good amounts of time just chatting about all sorts of things. It's a simple process, but these days in the acute psychiatric wards, there's probably no chance for that to happen. Nurses may be sitting in their office – their 'fish bowl' - doing paperwork, or they may be too afraid to go into the ward because it's such a toxic environment, or the environment may be risk averse, and they're not spending time with the patients. All of these things conspire to keep patients and nurses away from each other.

## After Larundel

7 Since my last admission in Larundel, I've been treated in the private mental health system. I've had two admissions to a private inpatient clinic – one in 2007, and one in 2009. This was a different experience altogether, though I have to say that in my experience the psychiatric nursing wasn't any better than that provided in Larundel – it was probably worse. From what I recall, the nurses weren't spending too much time with patients – I might get a nurse rock up into my room for five minutes and have a quick chat. And that was hardly therapeutic.

8 The nurses did not spend quality time with the patients. I had a million-dollar room and a million-dollar view with good food, but in terms of care, it wasn't great.

## The need for affordable supported accommodation and a buddy system

9 I have recently collaborated with Margaret Leggatt on a book called '*Out of the Madhouse: From Asylums to Caring Community?*'. The question mark in the title is important.

10 What we addressed in the book, is the importance of affordable supported accommodation; a place to call home is the missing link in the mental health system. Where people are offered clinical support for their mental illness and social support to help them stay in the accommodation.

11 I can't stress enough how valuable it is to have a place to call home. It enables people to find stability in their life, where a person can start to think of eating a healthier diet and take care of their physical health, bring friends, have pets, be in the same mental health area as their team, and see the same GP. All those things contribute to a person

staying well. Having a place to call home gives people a sense of hope and a sense of worth – that they are worth a home; a place to call home.

12 People on pensions cannot afford to pay rent or ordinary accommodation. It is incumbent on a government to supply people with affordable and supported accommodation. If a person needs support – clinical support, support in going to an appointment, or support in managing their health for example – this should be provided.

13 I am aware that MIND Australia (**MIND**) offers supported accommodation by way of houses where several people live, and they have a community there. Back in the day, they used to have these big old rambling houses where there would be many clients in a room each, forming a therapeutic community. I am not sure how extensively they do that these days.

14 The best thing about providing such a community is for people to have their mad comrades around them to offer support to each other and tell their war stories. I'm aware that MIND are constrained in what they can do because they might have limited funding. The problem is that there's nowhere for people to gather to tell their war stories – there are no drop-in centres, no art studios or places for people with mental illness to actually congregate and talk to each other, or support each other. We've been fragmented into this so-called recovery - individualised recovery where we are recovering in the community by ourselves in an atomised way, not talking to each other anymore, and not having the chance to talk to each other. That's a real problem.

15 Hospitalisation should be a last resort – we should keep people out of hospital by keeping them well. But if people are hospitalised, they shouldn't be discharged still unwell to the street or to stressed carers. The carer/consumer relationship is fraught anyway, and there is a further powerlessness experienced by the person being cared for. Instead, if they can be in their own place and have some independence, with carers coming in every now and then to help them, they will have a stronger sense of self. It's about discharging people to somewhere decent, humane, but in a supported residential service. It should give them a sense of belonging. I appreciate that we've got to have clinical services but we've got to keep people out of them as much as possible, and we should do that by giving them psychosocial rehabilitation and a chance to have decency in their life where they feel wanted, respected and valued.

16 I don't know how this can be achieved, but in my view, government should stop privatising all the housing stock – we've got to have public housing which government supports.

## A buddy system

17 People with mental health issues should have someone who is a buddy – a person who can help them catch public transport, encourage them to buy healthy food and teach them to cook, join a club, go to a café, and do all the sociable things that we as a right should be able to do. The buddy could be a person with lived experience, or it could be someone who's interested in that role – someone who wants to help care for people and get better things happening for them. Who it is may depend on how you assess people, and how you employ people.

18 The buddy system should not be funded through the NDIS. So many people with a mental illness miss out on NDIS funding because they don't meet the criteria. It should be separated from NDIS and funded by government.

19 A buddy system would help a person re-establish some stability in their life, and not be set up to fail. The worst thing we can do is set someone up to fail, and plonking someone in a house and leaving them is going to set them up to fail. So, they need support to be able to stay there.

## Healing centres

20 In my view, the idea of psychiatric wards in the back of hospitals – in concrete jungles – is an anathema to healing. Instead of these wards, we should have healing centres in every suburb – a healing centre which is both sub-acute and acute, but smaller and purpose-built, and near parks so people can go and wander around in nature. The centres could employ clinical staff, allied health staff, peer workers and have a range of healing options. Medication is important, and should be available, but there should be group therapy sessions, art and music therapy, sensory rooms, and therapy pets – not sniffer dogs.

21 There would be many of these healing centres – they wouldn't be big – but big enough to contain people who need containing when they are in acute phases. People can be in sub-acute phases and have a suite of healing options as well. I know this is pie in the sky, but in my view, this would be better than putting people in the back of a hospital. This is not a suitable place for healing – a small environment where people are squashed on top of each other, and there is no place to find solitude or peace, or to get away from people. That sort of environment – small, without those places – increases people's tension and anxiety, and fuels a toxic environment where people are setting each other off, and that becomes unmanageable.

22 As to how they would operate, if someone had a psychotic episode then, depending on where they lived, they could be taken to a healing centre closest to where they were living.

23 In a way, PARCs are an attempt to be healing centres, and they are a good idea in how they operate as a step-up, step-down facility. But there aren't enough of them, and they are time dependent. So, people only have a certain time to stay, and then they've got to get out. People need more than a few weeks there.

### Aged mental health care

24 I'm now over 65, and I have moved into the bracket of 'aged mental health care'. I had a friend who was in a public aged mental health facility, and I went to visit her there. It was the most soul-destroying experience of my life. I saw people wandering around the ward who looked overmedicated and under-stimulated. My friend told me that when she was there, they offered her no rehabilitation or recovery programs. She told me that they tried to tell her she had dementia and not a mental illness and wanted to shift her into a permanent residential care facility. She fought them on this and won. But they had taken away her hope. Within twelve months, she had suicided.

25 I think of her experience as toxic – they destroyed her. The idea that you can take away hope because a person is old is inhumane. When I went to visit, I thought to myself, *'I never want to end up in this place ever in my life, because there is not one shred of hope in that ward'*. It was grim pessimism – it's like, well you're on the scrap heap completely, we don't care about you because you're not going to be working members of the community; why bother to rehabilitate you?

### Thoughts on the peer workforce

26 There are millions of consumer voices out there that are conflicting; there is a lot of ideological conflict. So, we have consumers who believe in mental illness, and consumers who don't; consumers who believe in the medical model, and those who don't. The range of opinion is extraordinary and it is not a homogenous group. This is one thing to consider when we're contemplating a big consumer workforce.

27 I'm always amazed by how many people want to tell me what's happening in my mind; my subjective experience; and how I should think about it. That endlessly frustrates me, because I thought I had a narrative that explained myself to myself, but there are those who want to challenge it.

28 So, when we talk about the consumer workforce, we should remember it's a diverse group and there can be fractured ideas in that group.

### The notion of asylum

29 One of the things that is discussed in our book is the notion of 'asylum'. It has been completely lost in our mental health system. There is no longer a sense of asylum – we

don't even pretend to offer it - it's about contain, medicate and then discharge. The loss of asylum is a huge loss to our system.

30 Even the way that the word asylum has been used has become toxic – think about the debate around asylum seekers and being seen as queue jumpers and illegal immigrants. We've even made the word 'asylum' toxic in our community.

31 As an illustration of the loss of asylum, if we think of someone who has had a psychotic episode, they need time and space to get better. They're not going to get over that episode in 10 days. They might be in hospital for 10 days and then they get discharged because someone madder than you need your bed. So, the whole idea of providing a safe retreat, a safe haven for someone to regather themselves, and find their equilibrium and their sanity has been lost in the system.

32 At Larundel, you had time and space to get better, gardens to wander around in, and at least a languid time in which to find yourself. When you're in these situations, your mind is fractured, and you need to somehow get it together again, and you need peace and quiet in which to do it, not a place to be harassed. Asylum has gone – there's not a shred of it now.

**Women's safety**

33 We need to think about women's safety – in wards and in our communities. In the wards there is a lot of predatory behaviour that goes on and I think the fact that so many women feel so unsafe in the psych wards is a testament to how bad they are, and how bad they are for women.

34 We need to think about a women's only ward, or at least women's only corridors, and keep them that way. I think unfortunately blokes can be inappropriate and menacing when they're psychotic – I have seen some predatory behaviour from blokes. I experienced it in Larundel, and it wasn't pleasant.

35 I understand the pressure on beds has compromised the ability for there to be women's corridors, and I am aware that LGBTIQA+ people have suffered in those wards – discrimination and prejudice, for example. So vulnerable people in vulnerable cohorts suffer in a homogenised ward where you're putting everybody in a highly volatile situation.

36 A potential way to address this issue is to have agreed charters of behaviours that people adhere to. Perhaps if wards weren't so volatile and high pressured there would be a better chance for people to adhere to those codes of conduct.

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