Engagement Branch

Royal Commission into Victoria's Mental Health System

1 Treasury Place, Melbourne

VIC 3000

Please find attached individual submissions of employees from Melbourne Legacy. These do not represent the opinion of the whole organisation and have been grouped for ease of upload.

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**Issue #1:** Currently, the waitlists for access to community mental health services are far too long (an example, [redacted] has a three-month waitlist for inpatient treatment). This is causing disastrous outcomes for clients of the Victorian mental health system. My concern is that the waitlists aren't being managed correctly and are not systemically reviewed. A frequent occurrence is that once the client has reached the top of the waitlist their needs have changed so that service is no longer appropriate. This wastes time and gives a false understanding of wait times.

**Proposed solution:** Dedicated professionals to constantly conduct welfare checks and reassessments of clients on waitlists. This ensures that they maintain a link into the service, their case can be moved up or down according to risk factors and the client can be reallocated to another service if their needs drastically change (freeing up places for other clients).

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**Issue #2:** There appears to be minimal focus on early intervention regarding mental health. Education in schools regarding mental health is poor, and almost non-existent. When education is delivered, it is often by a teacher with minimal knowledge on mental health. Some schools use their qualified counsellors and psychologist to deliver the content, but this crosses boundaries and can cause students to feel uncomfortable if they are seeing the counsellor. This is where the money needs to be invested. Research has indicated that "good mental health literacy in young people and their key helpers may lead to better outcomes for those with mental disorders, either by facilitating early help-seeking by young people themselves, or by helping adults to identify early signs of mental disorders and seek help on their behalf" (Jorm, Wright & Morgan, 2007).

**Proposed solution:** Provide funding for a team of qualified social workers, psychologist and counsellors to deliver comprehensive mental health programs to every single school in Victoria in an academic year. Part of this program delivery should include the completion of a mental first aid certificate to ensure every young Victorian is trained to response to mental health incidents.

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**Melbourne Legacy**

293 Swanston St Melbourne Vic 3000
GPO Box 4312 Melbourne Vic 3001
Phone: +61 (0)3 8626 0500 Fax: +61 (0)3 9663 3015
www.legacy.com.au/melbourne
ABN 78 043 769 632

**Research:**

Jorm, A. F., Wright, A., & Morgan, A. J. (2007). Where to seek help for a mental disorder?. Medical Journal of Australia, 187, 556-560. Retrieved from https://onlinelibrary.wiley.com/doi/abs/10.5694/j.1326-5377.2007.tb01332.x.

**Issue #3:** Gaps in *"The Better Access scheme"* which allows Australians with a mental illness to receive up to 10 government-subsidised sessions with a psychologist each year. Along with the Medicare Rebates Freeze often leaving people out of pocket when seeing a psychologist (or doctor).

**Proposed solution:** Review current system – it has not been regularly reviewed. More funding is essential and more funding could be found through changing Fair Work regulation to prevent employers demanding "Medical Certificates" for one day off or a part-day off. This could potentially have the flow-on effect of freeing up doctors' appointments, emergency department presentations and allow some of the Medicare funding to be redirected into managing chronic or complex mental illness.

https://www.abc.net.au/news/health/2019-04-01/mental-healthcare-needs-major-re-think-experts-say/10957812

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**Issue #4:** People living with a Mental Illness falling through the gaps between NDIS and Current Mental Health System.

**Proposed solution:** Review the current systems, more funding and changes to the approval criteria to ensure less people who need support are going without. These could be achieved by cracking down on those who abuse the NDIS system (both service providers and participants).

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**Issue #5:** WorkCover claims for Psychological injury can refused due to "pre-existing conditions" that can be as simple as previously seeing a psychologist or councillor for a completely unrelated and now completed resolved issue.
http://www1.worksafe.vic.gov.au/vwa/claimsmanual/Content/6Impairment/6%202%205%20Psychiatric%20injury.htm

**Proposed solution:** Extensive reviews of current Victorian and Australian laws regarding psychological injury. Specifically, around judgement of psychological injuries being conducted by "Independent Medical Examiners" who generally do not spend long periods of time assessing the client and only have limited information in which to form an opinion.

Further from this, an investigation regarding WorkCover insurance agencies (CGU, Gallagher Bassett, Allianz and Exchanging) being offered financial incentives to push injured workers back to work as soon as possible (even if this may not be in their best interest).

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**Issue #6:** Issues when acting as a carer with CATT – the (crisis assessment and treatment team).

Carer's seeking support from the CATT are at the mercy of the competency and attitude of the respondents which lack standardisation in relation to this.

During times when one or more of the following is occurring,

- a psychotic episode
- self-harm
- feeling suicidal and
- feeling out of control

The carer has usually reached the limit of total helplessness and feels the need to call emergency services in order to action their request for help.

**Proposed solution:** Review current system – All first responders need mental health first aid training, the senior first responder at station level should have at his / her disposal a qualified mental health nurse which can be brought forward with support of Vic Pol to triage face to face in the worst case, and by phone in less critical cases, waiting for CATT response will cost lives, the pathway from incident to hospital needs to be at incident level and not require the action of a psychiatrist or psychologist.

Further enhancements at secondary triage at the hospital can occur, once life has been preserved and safeguarded.

**Additional note:** CATT case management is again at the mercy of a non-standardised service and it is obvious that even when under a strict compulsory treatment order it is usually the carer that need to ensure that the order is adhered to as the CATT uses a "soft" approach that does not work.

**Proposed solution:** Review current system and ensure that these orders are not only adhered to but enforced by the CATT, this will lift another burden from the carer's that are usually at wits end at this stage of the journey.

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**Issue #7:** Issues when acting as a carer with a loved one in a public system Psychiatric Unit.

Care's are at the mercy of the competency and attitude of hospital staff, this includes security guards and others.

Carer's need to feel that their loved ones are safe whilst in treatment and that they are part of the overall treatment picture.

Examples of failures in the system:

- Security guards laughing, acting un professionally and smiling at people grief and predicament during patient transfer or transport into Psych unit.
- People's bags and belongings not being properly vetted / searched on entry to psych units, including visitors, especially on return from day leave leading to;

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- drug use,
- pornographic material and other insensitive / triggering footage being watched by people who are unwell,
- power struggles amongst inpatients about who has these "things" / materials causing but not limited to emotional and physical abuse.

**Proposed solution:** Review current system, the soft approach is an approach that encompasses empathy, this works in many cases but having empathy doesn't mean not making the difficult but correct decision at all levels with transparency and the best outcome for the patient / unwell person front and foremost.

Decision makers need to be upskilled in the art of case by case appreciation and the decide and act decision making loop of the OODA loop. (Observe, Orient, Decide & Act)

All this can be achieved within the legislative and governance constraints and restrictions with a common sense approach.

Further training to security guards and support staff about empathy and professionalism, instant dismissal for un ethical behaviour after training has been conducted. (breach of code of conduct)

**Additional note:** CATT case management and hospital care do not correspond, the case manager needs to be involved **prior** to and be **part** of the discharge and future recovery process, family planning **must** be front and foremost with a clear pathway back to the psych unit during the compulsory treatment order period which does **NOT** include the whole onboarding with the CATT process.

**Proposed solution:** Review current system and ensure that there is a transparent and logical communication flowchart being followed with less duplication and no gaps, these gaps cause **loss of life.**

Yours sincerely

**Ken Tsirigotis**

**Chief Operating Officer**

**Melbourne Legacy**

293 Swanston Street MELBOURNE VIC 3000

GPO Box 4312 MELBOURNE VIC 3001

**Ph** (03) 8626 0500 | **Fax** (03) 9663 3015

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