The Royal Commission into Mental Health is a timely opportunity for consumers and carers who have experienced the mental system to openly discuss inherent problems within the mental health system as it is now structured and funded, and practices and elements that are not working as they should.

The key issues that I see are:

- The current mental health system is prohibitively expensive and mainly focuses on an acute response. There is little attention given to preventative strategies to keep consumers well and to empower consumers to keep themselves well through self-management of symptoms and holistic self-care.
- The mental health system is buckling under the pressure of a burgeoning population. Consumers are often more unwell when they finally get a bed, and yet they often spend less time on a mental health unit because of bed pressures. This means people are more unwell in the community, more unwell when they are admitted and more unwell when they are prematurely discharged from mental health units.
- Clinical staff are often overwhelmed, going from dealing with one crisis after another, trying to deal with very unwell consumers, and resulting incidents that occur on mental health units, as well as juggling all the mental health documentation and Mental Health Act requirements. Clinical staff in the current environment have very little time to engage with consumers or their family/carers. Clinicians need this time so that they can create a therapeutic environment and engage with consumers and carers/families on a meaningful level.
- Many mental health units currently offer primarily a 'pillow and pills' service. That is, mental health units are mainly used to contain a person until their medication takes effect. This does nothing to support medium or long term mental wellbeing in consumers, or their carers.
- Carers and families are often under utilised in the current system. Although clinicians know that they should be engaging with carers/families in family meetings or family consultations, due to time pressures and workloads this often doesn't happen. Carers and families are in unique positions where they have expert knowledge on the consumer, their situation and needs. However, this is a resource that is not well utilised or respected in the current system.
- There is a high turnover of clinical staff due to the demands of the work; the unrelenting pressures; threats, abuse and assaults by consumers; high sick leave; and difficulty recruiting new staff when others resign. This in turn creates an environment that is further under pressure as bank and agency staff, or inexperienced staff are used to fill the gap, adding to the cost of the system and creating a more unsafe workplace, and a more unsafe environment for consumers.
- It is in an environment like this that errors occur (such as medication errors, communication errors and incorrect observations); consumers and carers don't feel like they are being heard and respected, creating an atmosphere of disillusionment and high emotion; restraint and seclusion are used to 'manage' the situation (causing more trauma to consumers and clinical staff); an increase in sexual incidents; and an alarming number of critical or adverse incidents, or near misses.
- Safewards was rolled out across Victorian mental health units, however due to the inherent stresses in the system, it has not been fully adopted or embedded in many services. Instead, most units manage to hold mutual help meetings and perhaps have a folder of staff biographies.

However, the true therapeutic environment that was meant to be produced by Safewards has not been achieved. Instead, many mental health units operate under an atmosphere of fear, for consumers, carers and clinicians.

- As well as embedding Safewards fully as a program across all mental health units, priority needs to be given to creating a therapeutic program on units: employing psychologists to run group therapy and individual therapy sessions for consumers; employing sufficient occupational therapists to create meaningful group programs for consumers during their stay; employing sufficient social workers to address the significant social, financial and housing issues that many consumers face; employing peer workers in sufficient numbers and with sufficient work hours to be able to support every consumer on their Recovery journey. All this is needed to truly empower consumers to live meaningful and productive lives.
- Risk assessments need to be retired. They are outdated and ineffective ways of assessing consumer risk. Clinicians under pressure use them in a perfunctory manner, ticking the box that consumers' risk has been assessed, but they have a poor correlation with the real risk that a consumer poses to themselves. The only way to truly assess risk is for clinicians to have the time to engage with consumers and create a therapeutic relationship.
- Much of the funding that is given to mental health services is done in an ad hoc way and is limited in tenure. Some mental health services accept money for particular service provision but do not set up the program or employ the staff that they were meant to. The Department needs to provide a considered and consistent way of funding mental health services that does not rely upon short term projects or positions. The Department also needs to check that mental health services are providing the programs that they have accepted funding for.
- The Department should not give mental health services work to do that is not aligned with their core role of providing mental health care to consumers. For example, the recent psychosocial funding that mental health services received in order to tender out to community organisations that were previously funded directly by the Department is an inefficient way to provide these services. It means management of mental health services is spending precious time and resources in managing money and programs delivered by third parties, taking mental health services away from their core business of providing a mental health service. In addition, each time funding changes hands in this way, corporate fees and administration fees are withdrawn at each step, meaning that the money that is meant for service provision for consumers is lost along the way.
- Community mental health services are similarly under strain, with staff carrying huge caseloads on often part-time hours. There is pressure to discharge consumers from the service completely. This limits the therapeutic work that a consumer receives.
- Funding for peer workers and lived experience programs is thrown into the vat of money that mental health services receive. Often this money disappears with corporate fees and is reallocated to other parts of the service. There is only a limited budget for peer workers and lived experience programs, and it is not fully utilised for the purpose that it was provided. Lived experience managers are kept in the dark about what funding is available, and are not told by the mental health service what their budget is. The current system of mental health services accepting large chunks of funding and effectively chucking it in a cauldron with other funding has to stop. Accurate accounting for all programs should be provided against the funding received for those programs. Mental health services need to be accountable and the

Department needs to oversee where the money actually goes, whether it is used for the purpose given and determine if programs are actually set up when funding is provided for specific programs.

- The Department needs to endorse and fund single sex mental health units. Women's corridors are not enough. Safety for LGBTIQ consumers also needs to be prioritised. One possibility is to include LGBTIQ consumers on 'women only' units. This would improve safety for all.
- The argument that men only units would become dangerous places is not a valid argument to keep mixed sex units. Women should not be used as fodder to create a better atmosphere on mixed sex units. Women need to be kept safe so that they can focus on their Recovery, and not traumatised or re-traumatised by living on mixed sex units.
- In regional centres, there are specific issues facing mental health services. **One is the difficulty recruiting mental health staff**- one service I know has vacancies in 19 full-time positions. Specific attention and support by the Department needs to be given to assist in recruitment of mental health staff in regional centres, such as incentives for mental health staff to relocate from urban areas to regional areas to live. **The second major issue for regional centres is homelessness.** The Government needs to provide more funding for housing services and increase the number of public housing opportunities on a large scale. Many times mental health inpatient units are backlogged with consumers who are ready to be discharged but have no housing to go to. Consumers are often discharged to homelessness or inappropriate short-term accommodation such as caravan parks or motels. Motel and caravan park managers are increasingly reluctant to accept mental health consumers as patrons, leaving mental health services in a quandary about how to provide a duty of care to consumers who are discharged from mental health units. This means consumers are often 'lost to follow up' from community mental health teams as the consumers are homeless or couch hopping. This impacts badly on many consumers' mental health, as they don't receive community mental health care that they need and become more unwell on the streets. This in turn can lead to public safety issues in the community, which in turn leads to more media coverage about mental health consumers being 'dangerous' and increasing stigma against people with mental health diagnoses.
- Dual diagnosis- mental health consumers often have trauma histories from childhood, and if they don't get the therapeutic support that they need to deal with past trauma, they often 'self-medicate' with drugs and alcohol. **Mental health consumers who have coexisting drug and/or alcohol issues are often disadvantaged by their dual diagnoses.** Drug and alcohol rehabilitation services are reluctant to accept consumers with active mental health symptoms, and mental health inpatient services are reluctant to accept consumers with active drug and alcohol issues. This can leave people who have dual diagnoses in a no-man's land, where they can't find holistic support for either their mental health or drug/alcohol issues.