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

Organisation Name
N/A

Name
Dr Carol Silberberg

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
More education about mental illness to staff in hospitals to reduce stigma and discrimination for patients who are presenting to emergency departments and are admitted to medical and surgical wards.

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 lot of mental illness is either caused by or exacerbated by poverty and related problems such as inabiltiy to access timely and affordable general health care, homelessness/substandard/insecure housing, lack of supported employment or education opportunities. Ameliorating these problems through reducing poverty would help, such as increasing the payment of Newstart and DSP payments and increasing the availability of low income housing."

What is already working well and what can be done better to prevent suicide?
"There is a lot of evidence that risk assessments do little to prevent suicide. While suicide prevention is important, when there is only limited funds this comes at the expense of funding other important areas."

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.
See above re reducing poverty

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

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

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
"Better pay, better conditions (safe and adequate working facilities) and better training opportunities. Working in public mental health is often a soul-destroying enterprise. Ever increasing layers of management which seem to increase the paperwork and adminimstrative burden and take clinicians away from direct patient care. Admin support would also be beneficial

as the case throughout the health system (not just psychiatry) is that senior medical staff are still doing things such as typing and mailing their own letters as there is no admin staff to do so, which is not the best use of their training or time. Psychiatrists have little or no control over our working environments, little flexibility, and have much less compensation than in the private sector or interstate thus there is little incentive to remaining in public mental health. We have no backfill when we go on leave (despite the new EBA containing provisions for this, in practice the hospital denies it) which is often a disincentive to taking leave as things are much worse for your team while you are away and for you when you are back as the work has piled up. "

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?
N/A

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?
"Consultation Liaison Psychiatry - the provision of psychiatric care to patients admitted with medical or surgical problems in a general hospital - is a vital but overlooked field. CLP funding through the Victorian Department of Health and Human Services' mental health branch has remained stagnant over the past 20 years despite major growth in acute health services. The resulting inadequacy in CLP has resulted in poor quality care, increased length of stay, preventable behaviour disturbance and unsafe discharge planning. Consultation liaison psychiatrists report that without development and reform, the situation will further deteriorate. The underdevelopment of CLP is related to the mental health branch and acute health each having an expectation of the other to develop services, leading to decades of stalemate; the lack of visibility' of CLP within key data sets whereby the increased service demands, decreased responsiveness and capacity limits remain hidden and the absence of a model for service development involving both acute and mental health that demonstrates activity and quality and can respond to changes and growth within the acute health system. The lack of funding has led to major gaps in CLP services - most hospitals have no CLP outpatient departments so we are unable to follow up patients we have seen or to do important pre-admission assessments, such as seeing patients prior to transplants. Eating disorder services are dire and many of us working in CLP fear that it will only take a patient death in order to improve funding, in particular for eating disorder unit beds in general hospitals. QLD and WA have both reformed their eating disorder services and Victoria should be looking at implementing the QLD model. The number of patients being admitted to medical and surgical wards with conditions related to substance use, particularly ice, has escalated wtih no corresponding increase in CLP services in order to assess and treat the acute psychiatric issues that these patients present with. I could provide a number of specific examples but instead I urge the Commission to read the report that the RANZCP's Victorian Branch of the Faculty of Consultation-Liaison Psychiatry prepared in 2016 and adopt all of the recommendations contained therein."

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

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

N/A