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

Organisation Name
N/A

Name
Ms Amy Walker

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"I have worked within public health AOD (Alcohol and other drugs) / mental health - residential, outreach and community settings for the past 7 years. I have worked continuously in the front line client facing part of the mental health sector. I believe it is important to establish, from the outset that I advocate strongly for SUD / severe SUD (substance use disorder) to be treated, acknowledged and regarded as a mental health disorder. The DSM-5 has recognised that SUD is a mental health diagnosis. Yet, substance use continues to be siloed in Australia, separated from all other MH diagnosis'. Some organisations recognise dual diagnosis addiction and mental health, yet the delivery of service provision to people that fall under this label are predominantly left to the primary community sector. My clients are repeatedly turned away from psychiatric residential support, due to SUD, and then declined for treatment for AOD residential treatment due to their mental health complexity. A person presenting with significant cognitive dysfunction, disordered thought form, fears that are not consistent with reality and limited insight into risks to self and others would be admitted to a tertiary mental health facility if the presentation is believed to be in the context of a psychotic illness - such as schizophrenia. If the same presentation, with the same risks, was considered to be induced by substance use, it appears that the tertiary systems still consider SUD a life style choice and the person is far less likely to be admitted and treated by tertiary services. I previously worked for a government funded residential AOD withdrawal facility, that often declined clients that were hoping to be admitted for a 7 day withdrawal episode. Exclusions included: suicidal ideation, recent psych hospitalisation, recent self harm (aside from severe SUD), thought disorder, recent drug induced psychosis, compulsory treatment under a Community Treatment Order. It was deemed as risk management ? yet people with private health insurance, at the same or higher risk were able to be admitted to residential services. I spent a lot of my time advocating for highly marginalised / disadvantaged / complex clients to have the same opportunities as people with financial means / private health insurance. I also endeavoured to establish how private hospitals mitigate and/ or address risks that the community AOD services are adverse to. It is my understanding that private hospitals employ psychiatrists that are able to place people on Assessment Orders (AO) that require public tertiary services to hold the client for a 24 hour period and assess mental health. Understandably the tertiary services push back' on this as they legitimately have no available beds. Many of these clients that are not able to be provided help, end up with long term prison sentences or multiple short term sentences. Clients have spoken to me about how it is only in prison that they have a bed, company, therapy, structure and manageable medication regimes that bring about a reprieve in the severity of SUD and associated issues. Put simply I believe that at the crux of addiction / Severe SUD there is a lack of choice,. Where clients exhibit compulsion, diminished cognitive capacity and increased biopsychosocial crises, choice of treatment, far from recognising the increased severity of the condition, is further eroded. Substance resulting in further, acute and/or enduring mental health issues, frequently seem to be treated by psych services as requiring only

end game service provision. I have many clients that are homeless, have alcohol acquired brain injury, enduring psychotic symptoms, and SUD that are repeatedly turned away from psych and AOD services. High medication regimes also cause an increase in physical health issues, social isolation, behavioural issues and forensic issues all of which should trigger provision for additional care not the opposite. As a mental health care coordinator, withdrawal case worker, rehabilitation case worker and AOD care coordinator, I have been give the task of assisting people to not fall through the cracks. Yet, my Maori client who suffers from an ABI, enduring psychotic symptoms, loss of many physical functions and ongoing severe SUD and who is deemed a serious violent offender, has repeatedly requested residential support, but has been repeatedly turned away from all residential services - tertiary and community. The young woman that I met, when age was still on her side, who was raised in a home of violence and severely dependant parents, was imprisoned at a young age for the assault of one of her perpetrators. She has continually been deemed personality disordered by tertiary services and therefore denied psych admissions, is not considered eligible for residential AOD (due to being known as a serious violent offender) and is now an aging woman that has resigned herself to never getting her child back and to surviving with occasional respite in general medicine wards and prisons. "

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?
N/A

What is already working well and what can be done better to prevent suicide?
N/A

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.
N/A

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
N/A

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?
N/A

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?
N/A

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