Context:

As an adolescent I spent several years under inpatient and outpatient psychiatric care at public and private facilities in Melbourne (years approximately 2004-2009). Most often I was taken via ambulance or visited the emergency department to then be transferred to an inpatient facility, but I also underwent planned admissions. Most of my experiences in the private facility (Albert Road Clinic Adolescent Unit) which were all planned admissions were positive. I believe this was a reflection of good staffing and workplace environment, and probably adequate funds. Experiences I had in the public facility ([redacted]) were mixed. Whilst some staff showed compassion and High Dependency Unit facility provided a safe holding area, other experiences I had left me with lasting trauma that compounded my existing mental illness and took many years to heal.

Following is a brief outline of a few of my experiences to and suggestions of improvements that could be made to improve these scenarios.

1) Example of poor treatment in Emergency Department:

Insults in response to non-compliance. One experience stands out. A horrible psychiatric registrar at [redacted] Emergency Department.

Register said: "you are acting like a Borderline. You should look that up." On reflection I see that she was using a diagnosis as an insult to invalidate the seriousness of my condition, and those with Borderline Personality Disorder. I believe that she was in other words, in a very poor way, saying that my behaviour was attention seeking. She was right, however attention seeking behaviour is a serious indicator in a person who is mentally unwell, that something is wrong, especially a young person who has no skills to express their level of distress. I was afraid and confused and knew no other way to express my feelings than to be non-compliant and a danger to myself. On reflection I understand this doctor had probably had a long day at work, but as a young person this treatment affected me deeply, breaking my trust and increasing my self-hatred.

I was then given prescribed medication via injection, by force, with six security guards. I still believe this was a punishment for non-compliance – not for relief from distress. At least this is what was implied. I had informed them that this medication did not help me. I was not told in a clear compassionate way what was going to happen to me before it happened. Being told, even if it happened against my will, would have helped me prepare and process the experience. I don't remember any other medication being offered to help the situation, but I could not be sure.

"You've made me late home to my children." She said. I think I had run away from the ED. I wanted to go home, I wanted my parents, I was terrified and felt alone and felt unsafe in her care. I ran out onto the road hoping I may be hit by a car and killed, but I was too scared to make sure it would definitely happen. This occurred once I was in her care. I believe her treatment of me escalated my suicidal ideations and effectively led to this action.

She said things like:

"If you had the capacity to think of bringing your phone, you're not that bad are you". The police had told me to pick up my phone and bring it. It was my lifeline to my family. This accusation just exacerbated my self-hatred and feelings of being misunderstood.

Another experience:

I was intoxicated and hallucinating. I was at ED for medical observation and then psychiatric assessment. I was put into a 'family room' or 'parents' room' (I can't remember the name of it properly) with my parents. I was wanting to walk about; I was restless and confused from the intoxication. My family was given the task of staying with me and keeping me in this room, something beyond their physical capacity. I believe this is because there was no bed available. It was many hours, or so I remember, in this room waiting for assessment.

Guilt from being in with other medical cases:

The guilt was incredible attending emergency for psychiatric reasons. The feeling of wanting help in my distress, but the realisation that there were children all around me who were sick and may need care more than me. I was so afraid they would die because of me taking up the support services. I believe in retrospect that this was not the right place for me to be. But the right place does not exist yet, it would be a section of emergency we do not have.

Suggested changes to treatment in Emergency Department:

What would have been the right place for me to be held and assessed?

A separate space, adjacent to emergency, not in with general emergency. A place for intoxication and mental illness where others do not need to be exposed to the behaviours that may occur during a mental health crisis whilst waiting to be assessed in ED (self-harm, foul language, violence, simply the distress of somebody wanting to die or hallucinating). A place where you can be triaged to immediately that is secure. A place where your family can be with you. A place where there is lowered stimulation such as dim light, not the noise of the rest of the ED, where there are not materials around to self-harm with, where a person can be held safely until they can be assessed. A place where you can have a person and their family safe from the potential violence of other patients who are mentally ill. Where a person can be with their family, but their family isn't their security guards. A place which is secure so that there is no need for physical restraint unless really required. A place where the family can easily make the patient a cup of tea, get them a biscuit, and sit down with them whilst they wait in privacy but without taking full responsibility for them that is outside of their capacity

2) Examples of punishment and use of 'room suspension' (solitary confinement?)

There was a focus of punishment that I perceived a lot during my care and witnessing in the care of others in the public adolescent psychiatric impatient facility. I particularly noticed this with those with eating disorders. There was a system where an ED patient had to sit down and complete their meal, then sit for 30 minutes. If they did not do this, if they left anything at all on their plate, or stood up after eating, they would be taken into the HDU to be tube fed. The act of retubing a patient every time they fail to achieve the goals set seems cruel. It felt like a punishment.

'Room Suspension' was a common punishment used for behaviours such as non-compliance or for self-harming. Room suspension means spending 24 hours in your bedroom for self-reflection, not seeing anybody else except when meals are delivered to the room three times a day. I believe that this punishment was sometimes administered without assessing the situation fairly. Further misbehaviour would again lead to another 24 hours in room suspension, and so on.

In the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) A/RES/70/175 (Revised 2015) it is stated that:

" The imposition of solitary confinement should be prohibited in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures. The prohibition of the use of solitary confinement and similar measures in cases involving women and children, as referred to in other United Nations standards and norms in crime prevention and criminal justice, 28 continues to apply."

3) Security in Impatient Facility

On one occasion:

I was put in the room furthest from the nurses' station, with no direct sight, around two corners. Between me and the station were the rooms of two young men. One opposite my room had violently taken down his door and would have outbursts, he was withdrawing from ice I believe. Another got physically too close to me on occasions. Whilst he did not necessarily touch me, his behaviour was threatening, suggestive, taunting, and he would come too close in proximity, his positioning trapping me where I could not easily get away if I needed to. This was intimidating. I did not feel safe in my room. There were no panic buttons or locks on the door. Whilst I do not know if I brought this issue up with the nurses, I was not well, not particularly able to care or advocate for myself and was in the care of others. I should have been safe in the hospital and whilst nothing terrible happened I believe I was not in a safe situation.

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Improvements to safety in impatient facility

Improvements would include:

Panic buttons in all rooms absolutely necessary. More consideration of separating those that display violence (man who took the door down) and gender separation when choosing rooms based on the natural feeling of unsafety around men who are twice your strength who are mentally unwell.

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

Submission: 0002.0032.0010

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
N/A

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?
"Help lines have been an absolute life savers for me. I can not stress enough their importance. Particular thanks to Kids Help Line during my youth, I don't know if i'd be here without them. I believe that being in High Dependency Unit in a public psych facility helped me stay safe in some of my worst times."

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?
Families should be kept in the loop. Offered debriefing. Included. So much poor mental health in childhood and youth involves the family environment. You need to treat the family not just the individual.

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
More staff. Good staff. MENTAL HEALTH SUPPORT for staff. Some of the best professionals I had caring for me were under the management of a co-coordinator who had compulsory attendance of mindfulness and other self-development and self-care programs. This reflected in their work. You can't be helped by those who are not well themselves.

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?
Emergency response. The pathway from home via ambulance to care in ED to admission (or non-admission) to psych ward. This needs a lot of work.

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