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

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Name
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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?
"Having a doctor, counselors at the high school really helped my child as he was able to go and easily seek help and support. Improving the quality, knowledge, skill level, attitude of workers within the sector, including counselors at the school, mental health workers within the mental health sectors at the hospital, doctors etc. Maybe extra training. Improve GP's understanding of medications. More funding for adolescent mental health service at the hospital. Phone people directly for feedback after they have used a service as doing it off your own bat to complain is just too hard when you are going through so much."

What is already working well and what can be done better to prevent suicide?
As above and also prompt access to services when it is needed. My son needed to be admitted to an adolescent mental health unit in Melbourne over a weekend and there was only one mental health worker on per shift at the hospital in [redacted] He could have died because we had to wait. Who has died from a suicide that did not need to happen because of poor service? Plenty I am sure. It is horrible to be at the emergency department waiting to be seen by the ONE person that can help you with a mental health issue when you know there is a whole hospital there that can help people with their physical ailments.

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.
"Our experience with the mental health system was pretty horrendous due to a lack of quality workers. There is one adolescent psychiatrist in [redacted] and he seems to be in charge of the adolescent mental health unit at the hospital which should be being run as a team approach and it is not, I think it is more he is the decision maker. My son was referred to this unit by the doctor at the school and we got in that day and saw a provisional psychologist ([redacted]) which was good to get in quickly we then had an appointment to see her the next day (my son was suicidal and suffering extreme mental distress) she phoned us to cancel that appointment and said ""the team"" had decided at their morning meeting that my son should go on a mental health care plan and see a psychologist. I presume that this was this psychiatrist making that call as later on the manager of the facility told me there was no team decisions it was just [redacted] the psychiatrist deciding. [redacted] said that decision was made because my son had said he did not want to be counselled by this [redacted] at the unit. Honestly he was happy to see her the next day but long term he wanted to see a psychologist in the community [redacted] because we had dealings with her when he was

quite young and I separated from his dad. I thought it very unprofessional for his appointment to be cancelled like that with only hours of notice when he was in a suicidal and very mentally distressed state. Particularly as it takes weeks to get in to see [redacted]. When we did get in to see her she said my son was in extreme distress and needed to be assessed by [redacted] the adolescent psychiatrist and probably needed medication. If CAMHS had done their job properly he would have been assessed the day after being sent there by the doctor. It is a horrible thing when your son or yourself is experiencing a very acute mental health episode to be dealing with a system that is not functioning properly it is a nightmare to not feel supported by this system that is purported to be of use. My son did get assessed after I phoned CAMHS myself and spoke to a young girl that I think seriously should not have had the job that she did, dimwitted is how I would describe her. She wanted me to tell her why [redacted] thought he needed assessing suicidal and extremely disturbed was not enough???? I was going out of my mind and then having to deal with a fool. My son was assessed the next day he had deteriorated and was now showing signs of psychosis, it was horrible. Then this psychiatrist tells me it would be best if my son went to melbourne to be assessed in the [redacted] unit at the [redacted] hospital to see exactly what was wrong with him. this was very distressing and a shock as I had never even heard of such a place. I think this was on the thursday or friday and I said I wanted to think about it as our other option was to be treated through the home where [redacted] the provisional psychiatrist could do home visits. He was prescribed quetiapine. He then deteriorated on the Saturday morning and I rang the emergency number for the hospital mental health unit I was very distressed and we decided we would see how he went as to whether to get him into [redacted] house in Melbourne as I was worried he would get worse up there, he got worse that day. when I went to his room he was talking as if he was possessed by something not very nice in a strange voice, his eyes where flicking from side to side and he was in extreme distress, I sat with him for a bit but he managed to tell me that the voice in his head was worse when I was present. A month or two before this my son was cheerful and connected with life. It was the worst experience of my life and I am sure also of my sons. When I rang back a different nurse was on and she was receiving handover from another nurse. I heard in the background the other nurse say very tersely and rudely to ring me back after handover and I was told I would be phoned back. I waited over 40 minutes. It was decided we would get him into [redacted] and we would go up to the emergency department where she would meet us. We waited in emergency for hours. She was on the phone to another client in the community in distress. She was the only nurse in the entire hospital that could help us get to Melbourne. At this point there was a place available at [redacted] house where it is difficult to get into. Because of the wait to get him up to the hospital etc. by the time the nurse was ready to see us it was too late for her to do the mental health assessment that was required for my son to be admitted to [redacted] because he had had his quetiapine which zonked him out. We then had to wait until the next morning to have the assessment done which meant we lost the place that was available for him as they would not hold it. We then did not know if he would get in there or not and the only other option was to go to Shepparton approx. 6 hrs away. Melbourne is 3.5hrs away from us. Very distressing. The only place for us to spend the night was a room in the emergency department as I did not want to leave the hospital and have my son at home as it didn't feel safe and also he had settled a bit at the hospital as I think he felt safer and like he was going to get some help and find out what was wrong with him. I spent the night sleeping in a chair next to his bed. The psychiatrist had thought a big part of [redacted] distress was that he was struggling to get a good sleep and that sleep was really important for him at the moment. In the morning the new emergency department nurse came on at 7am. She came to see us I was guarding [redacted] door as I did not want him woken until the mental health nurse was available to come and do his assessment and start organising [redacted] paperwork admission etc. The mental health nurse the night before had said that she did

not know what time this nurse would get to us as once again she would be the only mental health nurse available and it depended on what else was happening with other patients in the community. The nurse allocated our room came to the door where I met her and talked to her outside so as not to wake my son. It was also very late by the time he got settled into the room from emergency. She was not sure on when the mental health nurse was coming and I explained to her what was happening and the assessment that needed to be done. She wanted to wake my son and assess his vital signs as that was standard procedure for the emergency department. I explained the importance of sleep for my son and that I was not waking him until the mental health nurse came. She argued with me and I argued back not being aggressive or mean or anything but being very firm. It was horrible. What I needed was understanding and support at this point in time and what I received was a nurse who thought she knew better than me when she did not understand our situation at all. Who knows what information she received in handover. I won that round but she came back again and hour or two later to say that maybe the mental health nurse would be there at 12pm and once again wanted to wake my son we had another argument she said this is the emergency department and I have to . Take his vital signs which I knew was irrelevant. She came back again not long after that and made so much noise at the door that my son woke which was ok because by now it was after 11 I think. The mental health nurse then came and we got into [redacted] which was an amazing relief that was a big process. [redacted] could have been taken to Melbourne by ambulance but we decided to take him ourselves with the safety locks on the back door. It was scary he was suicidal and also having thoughts of hurting others. My son was in [redacted] for a week and settled a lot. When he was discharged we did not receive his safety plan which is something they create for when they go home and tells the family school what to do when they are in acute distress and what they need. This was not good, I did not feel they had prepared us to take him home. We had an appointment on the Tuesday with the psychiatrist at CAMHS in [redacted] and had been keeping in touch and felt supported by [redacted] the provisional psychologist at CAMHS that my son was under. At that appointment my son was meant to be given the script for [redacted] which the psychiatrist at the [redacted] prescribed. Our appointment was cancelled and rescheduled for either a week or two weeks later. This was so unprofessional and really did not come up to the duty of care I expected from CAHMS. My son needed to start that medication and could not. My son decided he did not want regular counselling from [redacted] but would like it from [redacted] a community psychologist we already had dealt with. CAHMS said that was fine and we could do that. Not long after they decided to not have my son come under CAHMS any more as we were seeing [redacted]. I said what about his medication as that needed managing in regards to side effects etc. and we were told our doctor could handle that. I felt like we had just been given the flick. Turns out our doctor and another doctor that my son saw through [redacted] College did not have enough understanding of the medication to manage it at all. He ended up with extreme tiredness and gastrointestinal upset that started in November 2018 after he started the [redacted] in August. It reduced his ability to function and meant he could not attend school normally. Our doctor sent us to a paediatrician who made a referral for a gut specialist at the [redacted] and also a referral to an adolescent psychiatrist in geelong who is meant to be good (that was months ago and we don't have an appointment with the gut specialist yet and the appointment in geelong is not until September but we are waiting on a cancellation call, he also increased my sons medication to 40mg from 20mg we (that is me and my son) thought his symptoms actually worsened and thought it could be side effects of the medication. We decided to reduce his dose. I came up with a plan for this after doing some research. He is now on 10mg and the change in him is incredible, it is the best he has been since July last year. So like about a year. Before this I imagined there was a system there to help and support that would actually do that. I found I had to constantly be on the ball to manage against the extreme

imperfectness of this system. Being able to stay at [redacted] was fabulous. Fuel vouchers we received from CAMHS and being able to talk to [redacted] was great and having her get sense out of [redacted] house also helpled when I couldn't. My boyfriend was also amazing. Overall the system was not. Getting the flick from CAMHS was horrible ongoing support there even just for myself would have been good. "

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
Maybe it is the quality of the mental health workers. [redacted] for instance has no psychologists dealing specifically with autism. The adolescent mental health unit has a bad name around the town. I do not think one man having a lot of power in that unit is a good idea. There needs to be other psychiatrists there to bounce ideas off etc. and also to be available when he is not. Lack of funding. Lack of services that are useful and good.

What are the needs of family members and carers and what can be done better to support them?
Phone them to see how things are going that was helpful from the CAHMS unit at the hospital. That kind of support coming from the school would be good. I had so much liasing with teachers to keep them up to date and stay on top of my sons schooling so that he could pass some subjects. Someone at the school to help with this would be good.

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
"There is a university in our town. Maybe start programs like internships over the summer to give people a taste of the job or headhunt the students that look promising specifically. Like student nurses or students of psychology. I am in my second year of a nursing psychology double and I would be interested in something like that. Headhunt good psychiatrists for the rural hospitals. the adult mental health unit in [redacted] is know for its bullying and negative culture, I would not want to work there. Look at changing culture so others want to work there. Send people into these mental health units specifically to see what is going on exactly to talk to staff to talk to patients and families and then to recommend what is needed. I am sure at [redacted] adolescent unit CAHMS they would say more qualified staff are needed, more staff on over a weekend and definitely more that one psychiatrist ineptly running the show. It can't function under a team based care model when the team is not capable of that."

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