Yvonne Armstrong

- I have worked over 25 years in mental health having started in forensic psychiatry. I have worked in mental health for a government organisation focussing on tertiary rehabilitation (The Commonwealth Rehabilitation Service), and have also worked across general and medical wards, and now I have returned to adult acute psychiatry.
- The most confronting issues, on returning to an adult acute psychiatry ward in a hospital environment, (March 2018) is the rate of homelessness, and the rate of drug use. Working in the one of largest hospitals in Victoria, I would say that we discharge people back to the streets every second day. I would also say that at least 50% of our consumers are drug affected on admission.
- Crisis accommodation is stretched to full capacity In Melbourne and across Victoria with long waiting lists, and we can only negotiate with these services for the select few (i.e. non drug affected single mothers, especially those affected by domestic violence.)
- The Jeff Kennett government modified legislation around tenancy resulting to unaffordable accommodation for many. This legislation can be reversed and I believe this would free up more accommodation options for many on low incomes.
- What is working is the recognition mental illness has on families and carers, but I think we need to extend this recognition to the rest of the community. Everyone has a responsibility to look after their own mental health and to support those around them. It cannot be left to government resources alone.
- This week alone we had numerous incidents on the ward which took a toll on the staff. We had nursing staff and doctors being assaulted, furniture thrown, and staff on leave, resorting to bank staff. This is a serious and ongoing problem. Despite the magnificent working culture I am in, everyone was worn down. We don't have enough staff. And we don't have the resources to rehabilitate even in the short term.
- It is my understanding that new guidelines were developed around the emergency departments, where most consumers of psychiatry enter the service. These guidelines require a resolution within 4 hours, where either the consumer is transferred to a ward, or is discharged. The result is many who present as 'crisis admissions' relating to drug and/or alcohol psychoses are transferred to the acute psychiatry ward, Thus those needing treatment for a longer period are discharged prematurely due to bed pressure. This is a significant problem. On too many occasions I have had to reassure families, as to why their loved one is being discharged, whilst still very unwell, and not yet at 'baseline'. Often, in these instances the consumer is still expressing suicidal ideation and is at significant risk of self-harm. Not to mention the strain this puts on families and carers. I propose that there is a separate department in hospitals where these short term crisis presentations, such as drug induced psychosis can be addressed.
- I am promoting the idea where in additional to our existing services, a program is developed where services are based around interim housing. (3-6 months). And when I say housing, I am talking a bed, shower, and kitchenette. Like a bed sit. It does not have to be extravagant but enough for someone who is experiencing chronic mental health issues, to live and establish themselves, whilst being

supported to find something longer term. The accommodation resources we use, and filled with drug users, consumers with forensic histories, and predominantly very unattractive to those who just want somewhere safe, and clean to say whilst accessing supports. These people often opt for the streets to what is currently available.

- The situation is even worse for country residents. Can I suggest hospitals are granted the funds for this type of bedsit facility via a PP agreement, and contracted to a private company. Access is triaged via the hospital emergency department and the individual and or children are given temporary accommodation until they access social and community services within a definitive time frame. The hospital is responsible for this service and is given state and federal grants to manage this program.
- When I started my current position at a senior level in, I was very much starry eyed about the changes not only in the mental health act, especially with regards to the recognitions of numerous issues that need to be considered such as recovery focus, dual diagnosis, family violence, history of trauma, gender sensitivity etc. What I can say; it is well and good to be aware of all these complexities, but it is another thing to address them in an acute psychiatric ward. The reality is we are a band aid service for many, and many of whom are already familiar consumers. The complex nature of an individual's acute or chronic mental health presentation cannot be simply addressed via a acute mental health hospital inpatient admission.
- Trauma, like 'Family Violence' is the flavour of the month (year?). Not that it should be underestimated. But how we define it, and how we address it is another matter. Trauma by definition can vary from childbirth (applicable to everyone), to a child falling off a bicycle, to a car accident, to sexual abuse, to surviving a war zone. Yet we often paint these issues with the same brush in our handovers, and in our approach. Yes we can tick the box to say we have recognised it. It is really an individual by individual case. We do a lot 'to recognise these problems' and unfortunately we have consumers who 'cotton on' and exploit their experiences. We bend over backwards to we ensure we are doing the right thing, and by that, we are losing our own common sense, and exhausting resources.
- Another big issue is the culture in the general community; How much can the Royal Commission can influence this is another question. We now live in a society where any mental health issue is referred to specialists, such as psychologists, psychiatrist, and at a more significant level, psychiatric wards. I am not suggesting removing these services. I am suggesting a change in attitude in the community. I do not know anyone that has not experienced some mental health issue at some point. Be it anxiety, depression, social phobia etc. Not necessarily leading to a hospital admission yet nevertheless significant enough to take a toll, and if let untendered, result in a chronic condition. Other cultures understand that anxiety, depression grief, etc. is part of life. Yet we taken on the American model by PATHOLOGISING any diversion from the 'norm'. It is normal to be anxious at times. It is normal to be depressed or low. It is not normal to seek specialists to fix these problems in every instance. I think this attitude needs to change. We need to learn from other cultures,

where everybody in one's community can support these issues. Starting with family, friends, extended families, and other significant members in one's community.

- Mental health is everyone's problem: I propose we promote a society 'from the top down' to support those around, and to seek support from our family and friends, when in need. (and perhaps in conjunction with specialist services, such as a mental health plan) This may alleviate the burden on already exhausted resources.
- NDIS is the most complex, convoluted, difficult and inefficient program ever I have encountered, especially with regards to mental health. The amount of time and resources it takes to get someone an appropriate package is just ridiculous compared to previous programs. I consider it a very poor attempt to make up for what was the Commonwealth Rehabilitation Service, (prior to transforming this department to a Mickey Mouse employment focussed service). It was a nation-wide Service, available to all citizens and residents, and focussed on rehabilitation and recovery. CRS Australia was made up of professional people who thoroughly understood the implications of both physical and mental health conditions, and who were best located to access local resources tailor made for each individual. This of course is an expensive enterprise, which is why after 40 odd years it was shut down. The service was voluntary, and yes there were waiting lists of people who wanted to attend, but were seen in a timely fashion. If Victoria can somehow develop such a service, which may be only state based, we would have something to be proud of.
- People with ASD (Autistic Spectrum Disorder) encounter social problems, isolation, and economic challenges which can lead to 'crisis admissions'. It is great that this condition is now more readily recognised, and there are a growing number of services for youth. However, I have seen many adults admitted to the ward, when their long term untreated condition has led them to disaster. Unfortunately to access a formal diagnosis and treatment now, as an adult in Victoria is an expensive process and not supplemented as with other conditions. Ironically it is not considered a mental illness, yet people with these untreated conditions can find themselves in an acute psychiatric ward more readily. More policy work needs to be done in this area to develop appropriate and positive outcomes for adults with ASD.

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