

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

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Name

[REDACTED]

What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

"Language - When you use the term 'carer' it changes the relationship between two people. Where a person may have been a husband or wife, mother or father of someone with a mental illness their identity changes to a task oriented label such as 'carer'. The term 'Carer' is very disempowering to the person with the illness and therefore not recovery orientated. It infers that the person with the illness needs something done for them when often this is not the case. The term 'supporter' or 'support persons' is by far a better reference. EG: ""Who is your carer?"" v. ""Who are the people that support you?"" More publicity about mental illness. Print MHA forms in other languages. eg. Consent for ECT treatment form is only written in English. Imagine you are in a new country, admitted to a psychiatric unit and asked to sign a form you couldn't understand that was agreeing to an extreme treatment. It is frightening; leads to anxiety; agitation and aggression. "

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?

HOPE teams for suicidal presentations to ED provides extra support to individuals however each service model including criteria is different. Consistency needed. Have better communication between primary/secondary/tertiary services. Have a 'no wrong door approach' rather than a 'check next door' approach. Headspace does not service those over 24yo. Mental illness has no age barrier. Evidence says that those experiencing mental illness in their teenage years will have their developmental stages interrupted. A 27 or 28 year old can be developmentally still a teenager and yet excluded from youth services. Use more MH and AOD peer workers in schools and training. Currently peer workers are not funded in CAMHS or youth AOD.

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

HOPE teams work well however we need consistency in criteria and expansion to all emergency departments including weekends. People don't always attempt suicide Mon-Friday. More education in schools to counsellors to understand confidentiality and the need to liaise with parents.

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.

"Silos make it hard. There is a significant amount of presentations to EDs and MH services that are drug related and/or mental health. The minute you mention drugs are involved the mental health services and EDs tell you to go to AOD services. There are no 'warm' referrals. The onus is on the patient who because of the drugs and anxiety may not be able to make the calls required. They need the support of a worker to sit with them. This is my son's experience. He desperately

wants to abstain from drugs but because of his mental illness, BPD, Anxiety Disorder and Substance Dependence, he is unable to speak to people on the phone and requires the use of PRN medication to meet and talk with people. When we do get to an AOD service they say he needs to be in mental health services. We recently had the experience (again) of being admitted to a detox service. On discharge they said he was welcome to come back but he would need to ensure he had rehab. lined up. We informed the staff that he was on the waitlist for AOD rehab and were told ""No he needs Mental Health Rehab not AOD Rehab. AOD Rehab can't deal with his mh problems"". He was discharged from Detox without medication. The next day he presented at a Hospital Emergency as it was the weekend, he was agitated and discharged without medication. They told him he should seek AOD services. This all happened within 3 days. People with dual diagnosis are forced to navigate between services, different criteria and different catchment areas. My son is lucky that I have contacts in services because I work in mental health but without those personal contacts there is no way we would be able to get the services we need. We need more 'navigators' who can liaise with multiple services and have dual diagnosis competency and experience. One recovery plan rather than multiple plans created by multiple services. Its too confusing for consumers to have multiple plans. Share one recovery plan between services that all can access. We also need more family support services for dual diagnosis. Expand the Sharc services to include dual diagnosis services and resources."

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

"More services for the LGBTI community to deal with dual diagnosis. Language barriers - services assume people from CALD communities have the same understanding of mental illness. Some communities dont even have a word for mental illness. If you dont meet the threshold for a tertiary mh service eg. community clinical mental health service, you are told to go to your gp. GPs dont always have accreditation in mental health or are unable to contain a person. They will then refer someone to an 8 session psychologist which is useless. People find it hard to engage with someone who can only talk for 8 sessions not to mention the out of pocket costs. Poverty. The public housing waitlist is so hard to get into people are forced to use private rental which leaves them with no money at all to pay for medications, utilities, food etc. When they do get public housing they are full of people using drugs or offending so end up in a cycle of relapse."

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

Family members and carers need to be just that! Not case managers. Clinicians need to understand confidentiality and carers rights. Identifying carers Family interventions eg. Single session (framework) with families. Family work needs to be considered core business. Clinicians upskilled in working with families. I know I am desperate for some respite (and sleep) but there doesn't seem to be any services that can assist. The financial impact is huge and I work almost full time. Professional counselling (not just peer). Family needs assessment followed by appropriate intervention to be routine.

What can be done to attract, retain and better support the mental health workforce, including peer support workers?

Lived experience workforce - funding for specialist peer supervision to be developed and delivered Dual diagnosis mandatory Acknowledging and remunerating mental health workforce as a

speciality

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?

People often need the assistance to link them into community. That is not simply a phone call but to attend the first sessions. Outreach.

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?

AOD and Mental Health. The sectors need to be integrated and skilled appropriately. More outreach services. My son stays in his apartment for weeks at a time unable to leave because of his anxiety.

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

Increase outreach. Integrate mental health and AOD. Build more CCUs.

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

My son will not receive NDIS because of the discrimination against people with substance dependence and BPD. We rang a Community Mental Health Service (NEAMI) and were told they could offer some support but only we applied to NDIS and got knocked back. What a ridiculous waste of valuable clinician time and report writing when you know you wont get NDIS! We had a case manager for 3 days. CATT had been contacting my son for a number of weeks when he was finally referrred for case management. We attended the first appointment and met the case manager. The registrar contacted my son's psychiatrist and once the service found out his diagnosis of BPD and Alcohol dependence they told us they could not offer a service and we should go to AOD services and continue to see my son's private psychiatrist. Nobody asked if we wanted to continue to see the private psychiatrist. We cant afford to keep seeing him and my son has complex needs which the private psychiatrist in unable to manager.