

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

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N/A

Name

[REDACTED]

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

"Understand that some mental illness is short term, some is chronic, it can be episodic, Not all mental illnesses are the same. They can be as diverse as physical illness (almost?) and require different treatments, supports, A good service model of treatment, recovery and care that is known about in the community will greatly facilitate the community's understanding of mental health. The community understands that physical health challenges may be one-off with full or partial recovery - surgery that removes malignant tumours, stents for hearts - and that other conditions can be chronic and outcomes vary greatly - strokes, diabetes, back pain. The community accommodates people experiencing the range of physical illnesses. I don't believe that the community understands that mental health conditions and responses to conditions are also varied. My observation is that the community perceives mental health as a single condition and if one person can recover then why can't the others? A good mental health service model requires a range of professionals. Education and training opportunities in the community will promote a knowledge of the MH service system and model. Opportunities for mh practitioners to practice their profession and grow in their profession will improve the status of the profession and create a better community understanding and respect for the field of mental health services, for the people who require these services. and for the mental health conditions people experience. And yes, this involves resourcing the sector to create such a system. Sorry, but the cost of not doing this is adding to the suicide rates, mental health morbidity, loss of economic activity and a loss of economic engagement by so many sufferers. And it will be a huge factor in dealing with the stigma and discrimination experienced by sufferers - to the detriment of the community and a good society. "

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?

"For my daughter who has been suffering her mental illness for over 20 years, there is nothing in the system that is working well to prevent her from taking her life. The private psychiatrist is engaged in trying to treat her so that she can experience positivity in life and to be removed from suicide ideation. There is no outreach support from the public specialist mental health system. The outreach support provided by the newly formed [REDACTED] program (works with long term sufferers of mental health conditions and at risk of rehospitalisation) is totally inadequate in supporting my daughter through this period. My daughter's words to me after I discovered her suicide plan were "" Mum, I can't take this any more. I don't want to go back into hospital and go through more treatments that might or might not work and the treatments are awful. Hospital is awful. I just can't do this any more. Can't I be allowed to die? I've tried so hard and I'm so tired"" Refer to the

response to the question immediately below to get some picture of what system of interventions might improve my daughter's quality of life. I ask you to do this with great consideration. My daughter's life is at risk and I do believe that an appropriate system of treatment and support would keep her alive and give her opportunities to enjoy life."

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.

" My experience as a carer relates to a daughter who has lived with mental health issues for 20+ years. It is extremely difficult to access timely appropriate mental health services outside of crisis situations. The current scenario is that a person must demonstrate an acute situation such as suicide attempt or severe harm to another person in order to receive a timely, appropriate response from mental health services. An outreach professional practitioner / case manager is usually appointed to support that person post peak-acute period usually for a limited period. Following that response, the service rapidly reduces and the person is disengaged from the service system. And then the cycle of deteriorating ill health recommences, usually prior to the person having recovered to the level of stable health,. What the service system considers to be recovery and what the individual experiences as recovery are two different notions. Under the current system, there is no longer any PDRSS (Psychiatric Disability and Rehabilitation Support Services) that would provide ongoing support post the specialist mental health service response. My experience is that at the time PDRSS were in operation, there was a very poor interface between the PDRSS and the specialist mental health service; consequently people in the recovery process would fall out of the system and recommence their cycle of ill health. Hence the service model wasn't effective. However it is a service model that could work well for the individual if it were functioning properly. In fact this approach or including PDRSS type services within the current specialist mental health service would provide a seamless and effective support to an individual experiencing both short term and chronic mental health conditions. A second factor in the individual's recovery is the standard of service that a practitioner provides. These standards relate to 1. qualifications, 2. personal attributes that support a trusting relationship 3. the scope to provide an adequate level of service. In relation to 1. I can confirm that the inadequate qualification of practitioners providing post-acute and PDRS- type care is a major factor in my daughter's recurrent episodes of ill health. At a time when she has been supported by MH nurses and / or psychologist -trained case workers, her recovery has been solid. When she has been supported by support workers who do not have at least these qualifications, her recovery has not been achieved or sustained. I believe the latter group of support workers would be effective in relation to day to day independent living skills. In relation to 2. above, my experience demonstrates what research tells us - that a trusting relationship between the individual and practitioner is critical to the outcome of that service. When my daughter was engaged with a long term professional practitioner in whom she had trust, her recovery and the stability of her health was sound, providing 5 years of stability including employment, social engagement, totally independent living. With the withdrawal of that service, and the uptake of a new service (introduced to the system in 2018- called [REDACTED]) which provided an incompatible and Certificate qualified person, my daughter's health has not even started on the road to recovery. Hence her distrust of the support worker and her lack of confidence in him is severely, and currently critically, impacting on her capacity to recover from this current episode. In relation to 3. above, the individual requires access to the practitioner based on her needs, not on the prescribed levels of engagement placed by the service. My experience demonstrates that the MH service system expects individuals to recover within a prescribed amount of interaction and a prescribed

period of time. The language used in the terms of the service at the outreach practitioner level and the practice are not consistent. In the early years of my daughter's mental health conditions, my daughter was initially engaged in the public system post-suicide attempt and then discharged. She then engaged with a private psychiatrist. Needing more continuous support but at a less specialised level, my daughter was then able to attend her private psychiatrist and receive outreach support from the public mental health service. This worked effectively over an 8 year plus period, until the public provider decided it would no longer work with the private sector. My daughter's health has reflected this change - for the past 20 months, her health has deteriorated, it is very unstable, she has experienced a critical episode, she is no longer at work nor has a social interactions, and she requires a high level of daily support from her parents."

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

"In my experience the key drivers are the quality of the services that are available. I live in a regional centre that has been relatively well resourced (compared to the more remote towns) in mental health services. When the specialist acute health service is functioning well internally (and the very public awareness of the bullying culture informs when the service is not functioning well) then the quality of the service and its engagement with sufferers and their families is good, with positive outcomes for the sufferer. Conversely when the service is dysfunctional, then there is less engagement with sufferers, less ongoing support and the sufferers fall through the safety net. When there is poor interface between the specialist mh and other services, including the private mh sector, then more people are denied timely and appropriate service responses and are less likely to recover, increasing the numbers of people in the community suffering a mental illness. In the aboriginal community, I think that there is an issue around culturally appropriate engagement in the mh services even within the ATSI specific services. Intolerance of difference in many rural communities does not support good mental health, especially amongst young people. Community education and awareness is critical in these communities and these too need to be done in ""culturally appropriate"" settings e.g. at local agricultural shows, catchment management forums, field days, school sports, local community activities such as local festivals. Engagement of the community in the provision of awareness activities is also important, rather than having ""outsiders"" setting up awareness programs. "

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

"Provision of education about different mh conditions, their treatments, their outcomes - in personal groups, in preference to online. Resource flexible respite for the carer and / or the sufferer. Recognition of the level of support carers need to provide "

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

"A good mental health service model requires a range of professionals. Education and training opportunities in the community will promote a knowledge of the MH service system and model. Opportunities for mh practitioners to practice their profession and grow in their profession will improve the status of the profession and create a better community understanding and respect for the field of mental health services, for the people who require these services. and for the mental health conditions people experience. Mental health professionals require status, often reflected in their qualifications required, pay levels and capacity to realise their potential within their roles And

yes, this involves resourcing the sector to create such a system. The cost of not doing this is adding to the suicide rates, mental health morbidity, loss of economic activity and a loss of economic engagement by so many sufferers. And it will be a huge factor in dealing with the stigma and discrimination experienced by sufferers - to the detriment of the community and a good society."

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?

"My daughter is really wanting to be able to have periods of time with her peers where there is a mutual understanding. This time needs to be constructive as well as enjoyable. She is keen to be involved in film nights with peers, board games, wine tastings etc - mainstream activities but within the company of understanding peers. And age appropriate I propose one local agency be funded to provide peer activities for young people suffering mental health issues (15 to 25) and another to provide peer activities for people suffering mental health issues (25 to 40) and a third provide for those aged over 40. Then the individual has the opportunity to select one over the other if they are in a changeover age range. And the three different agencies will want to be perceived as good at providing their particular service, and the agencies can collaborate and share the skills of the coordinators. Coordinators should be professionally qualified practitioners - MH nurses / psychologist/ social worker (Not Cert 4 practitioners). They will be assisted by the participants. Or an assistant position of a person with lived experience could be included. I have not seen peer administered /coordinated activities work. There is too much pressure on the Lived Experience worker. "

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?

"Ensure current services are adequately staffed with appropriately qualified and empathic people who have the level of constructive support within their organisation to provide treatment and support in response to individual clients and to be trusted to use their own professionalism to inform their practice - alongside evidence based practice. Micromanaging in the service system is not in the interests of the client or a healthy productive staff. Improve links between the public and private sector. Provision of directly funded services. Since the introduction of NDIS, there are no quality assured critical mass services that individuals can go to. Now MH programs dont exist as the private or profit-making NGO doesn't have the critical mass of participants to make the program financially sustainable - hence people miss out on good programs / activities that support their recovery"

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

N/A