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

Organisation Name
N/A

Name
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What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"educational programs in primary and high school that provide understanding of anxiety , symptoms, how common it is and ways to reduce it. Useage of other non clinical words to describe anxiety - eg unsettled, restless, problems concentrating. Lessening the medical model - illness based approach as it is important for young people to normalise their experience and not view themselves as very unwell. Solid strategies to address finding balance in life , find focus, harmony - teachers modelling how we can respond to situations rather than react. Incorporating this in class teachings for behaviours and social relations to reinforce healthy communications.high school - consistent health messages, programs that incorporate how to identify if you or a friend is experiencing difficulities that could be signs of being our of balance, - anxiety / depression. A gap exists in terms of educating young people on helping others with mental health issues. Despite overt confidence in teenage men, overall there is a very low skill base of supporting a mate who is in need of support. The reasons are many, but practical education based on scenerios is a key to build confidence and knowlege during their secondary school years.Very important to have programs that skill students has to how to assist their friend, what to do, who to talk to. For example, emphasis on human connection rather than texting a friend in need, or facebook. How to tell a parent or offer to go to the gp with their friend/ seek advice from a school counsellor How to lessen social isolation of individuals and what to do to assist a friend with too much stress to re engage. Education of how not just bullying but not inviting people to be in social groups/parties etc can be damaging. Programs to encourage and build ways for students to feel and demonstrate empathy. Importance of school cultures to also espouse and demonstrate humanist values of respect, empathy and emotional intelligence"

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?
"There are a number of good organisations that promote mental health education - I think the voice of human contact and follow up is lacking in some organisations. On line chats are good, although more careful monitoring and follow up by the organisations is important. Schools having mental health practitioners at their school vital - this is in progress. Education awareness lacking in effects of alcohol and drugs on mental health. In particular at secondary level it is common for rec drugs such as speed, cocaine to be regularly used at parties. Education about relation between psychosis and onset from drugs/alcohol needs to be front and centre of any MH program. It is so dangerous for young men, who feel they are invincible - normal, to not be aware of the neurological issues and exacerbation of issues of feeling down/anxious. Having people with lived experience to discuss this at schools. symptoms of psychosis - how early intervention can often prevent an episode.. Parents to also be aware and offered programs at the school to increase their education of MH, promote communication with teenagers and reducing stigma issues that often

result in parents feeling helpless and not having friends they can confide in "

What is already working well and what can be done better to prevent suicide?
"Our experience cannot address what is working well. Prevention suggestions - often parents are the last to know that their child has been having suicidal thoughts. Secondary schools/advertising/ sports clubs etc programs that give guidance as to what to do if your friend said he /she was going to harm themselves. Emphasis on clear thinking, options - safety issue that needs someone else to know asap. The value of keeping your friend safe more important than keeping a secret or not wanting to 'worry ' their parents. Highlighting this early intervention can avoid further distress of their friend. Clinicians counselling young people need to adhere more to the Code of Ethics concerning patient safety. Concerns about breaching confidentiality of young person, say male age 22 having suicidal thoughts without a plan can be communicated to parent/carer by asking them is it ok to share this information to improve their safety. If the clinician is worried then safety of the client becomes the key issue and over rides confidentiality. Safety plans - clinicians role to include this . Follow up with a client who doesn't rebook following a few sessions who has suidical ideation. Communication with Primary GP referrer and visa versa GP's administering meds for MH conditions need to regularly check on their patient; provide education on dangers of stopping medication, normalise the desire to stop it and options to reduce meds if they are feeling numb, tired , sexual issues. GPs need to have an interest in mental health or else refer them to another GP who has an interest. I am aware of where a Gp administered antidpressants, never read the psychologist reports, never contacted their patient pre or post hospital admission and was at a loss as to where to send their patient upon discharge from ED , and claimed they didn't have an interest in mental health. Psychologists who are concerned about their client when they shift to another psychologist have a duty of care to contact them to discuss their concerns. When clients are feeling unwell, with suicidal issues the safety of the client is best served with sharing of information. ED has to improve substantially when young people in particular visit feeling suicidal. ED's need to have a comprehensive psychiatric assessment for every person who attends in that condition. 2 clinicians need to spend time with them to confer before any plan to say go home. There needs to be a safe place in every major hospital for short term stay for several days to observe/ assess and make sure self harm does not occur. Moods fluctuate, psychosis may exist which you need time to diagnose. This would also give time for referral to appropriate services and suggest that someone from the service visits them in person. I am aware of a situation in 2017 where a mental health nurse in a major ED hospital spent approx 15 minutes talking with a young male who ticked many boxes of high suicide risk. As the male didn't have a clear plan, but expressed feeling very depressed, in a hole, wanted to go to sleep and not wake up was told to go home and seek counselling. There was no interaction with the family , questions of previous suicidal thoughts. There was no follow up with patient or phone call to GP. The assessment was he was at low risk of suicide. Within 48 hours he made a serious attempt . The male had early signs of psychosis, had an episode and he became a chronic patient. This was devasting for the patient and family. Trauma for young people who attempt and then become deeply entrenched in psychiatric wards is a frightening and traumatic experience. entering the system. This is particulary important for those who have self harmed. They require Trauma informed recovery support.Safety plans need to be developed prior to discharge and communication with families is vital. Families who know their member so well , should always have their concerns noted on clinical notes and communicated to the treating team. Prevention of another episode of self harm /attempt can be avoided if communication between clinical teams is enhanced. For instance, we have experience the hospital and [redacted] not communicating verbally about the shared patient. Reliance on reading case notes was inadequate and often didn't occur. Communication

of suicidal plans between treating clinicians and family ought to be a given. the treating team needs to contact the family who are primary carers about this and not rely on the word of a patient that they have told them. c Not having Psychologists can also lengthen the stay which is not appropriate. Patients should be able to access a psychologist in a public psych ward without permission from the treating psychiatrist. There is inherent discrimination in this approach, as medical patients with an injury are offered a selection of allied health to ease their condition. As a slight "

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.

" Psychiatric wards need to be available exclusively for young people b/n the age of 18-25. Therapy, activity programs that give hope and are tailored are essential for this age group, especially when it is their first admission. Being with long term,chronic and older patients lessens their exposure to confronting chronic patients,who may reinforce this is how they are going to end up. Often patients wandered around, seemingly waiting for recovery with very few programs. Im aware of lengthy periods at the [redacted] when there was no psychologist for at least 10 weeks and then few months later again. Young people require individual psychological therapy to assit their recovery and chances of not crashing post discharge and then re entering the system. This is particulary important for those who have self harmed. They require Trauma informed recovery support.Safety plans need to be developed prior to discharge and communication with families is vital. Families who know their member so well , should always have their concerns noted on clinical notes and communicated to the treating team. Prevention of another episode of self harm /attempt can be avoided if communication between clinical teams is enhanced. For instance, we have experience the hospital and Headspace not communicating verbally about the shared patient. Reliance on reading case notes was inadequate and often didn't occur. Communication of suicidal plans between treating clinicians and family ought to be a given. the treating team needs to contact the family who are primary carers about this and not rely on the word of a patient that they have told them. c Not having Psychologists can also lengthen the stay which is not appropriate. Patients should be able to access a psychologist in a public psych ward without permission from the treating psychiatrist. There is inherent discrimination in this approach, as medical patients with an injury are offered a selection of allied health to ease their condition. As a slight "

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?

"practical support - early education of what the illness is , the variations and nuances of it, progression and what may be expected. for example - psychosis is complicated , as a family were told 3 months after diagnosis that despite medication it varies, comes and goes regularly - not a linear progression of recovery. practical ideas/strategies on how to support your family member ideas on how to talk to their friends, suggestions on how to reduce isolation of the member, building activities into their life a programs that need to be suitable for different age groups - programs lacking for 20 plus Having walks, hikes, weekend aways for them would be helpful.

meeting other parents whose children recently experiencing first episode/hospitalisation be helpful. Currently receive a support worker from the hospital but not opportunity to meet other parents "

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

"need to improve the level of experienced clinicians at [redacted], as is my experience. Psyc graduates, first time jobs due to pay and experience proliferate at [redacted] Clients with complex issues, require very experienced clinicians . Leadership to recognise the value of theraputic interventions / counselling This would therefore increase the opportunities for these clinicians to be a central part of mental health centres and reduce the reliance on medical interventions such as meds, incaseration Retain them with decent salaries, regular supervision , training. Respect of differences and empowering the consumer of mental health services to have offered a suite of allied health clinicians without the authority of treating psychiatrists (as applies in psychiatric wards) "

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?

"An individual approach based on principles of humanism, respect, and treatment that mirrors the level of patient support for those with a medical illness. Provide safe wards at hospitals for suicidal patients so they can stay for several days for assessment and appropriate targetted support when discharged. change the bias that unless you have a definate plan you are a low risk and are sent home. Public psych wards must always employ Psychologists that are available on each ward Prior to being admitted consumers and their family in attendance must be informed of what to expect. Patients should receive their meals and drinks in melamine plates/cups instead of plastic takeaway /poly cups - again so different to medical patients. Provide [redacted] centres that are for clients who are young adults - 18-28 or so. the current system mixes young first episode patient with chronic older patients. In order for organisations such as Headspace receive funding centres require a much higher level of clinical leadership, accountability and supervision of clinicians. There must be clinical standards for all clinicians, including sessional contractors in terms of note taking and responding to and refering clients with suicidal thoughts with other major issues to receive an multi discipline assessment . Clinicians must t investigate and assess risk factors,(read the GP referal) . Clinicans must back up their counselling with diagnostic tools at specified intervals that need to be communicated to clients. Meaurement of stress, anxiety, psychosis, suicide risk provide important clinical information to enhance safety and progress potentially of recovery. Reports to GP's must occur to a high clinical standard. clients who are on medication need to be reviewed /followed up before assuming they have ceased sessions and prior to final report to GPs. Individual approach - clients seeking counselling should be offered this, particularly post psych ward discharge. Family sessions may be too confronting for some clients - give them a choice of what they prefer Create a culture of sharing information between clinicians, gps, and with consumers and families. Respect and value of information provided by families to clinicians Improve support for people who are unwell by requiring clinicians who are assessing them to ask if they would like a family member to attend the session. this can help with

information and provide support for the person. It's often overlooked that they may not be in a position to answer and hiding things is very common - drive this with the value of patient safety is paramount "

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
"Allow some cases to be examined at the commission Office of Chief Psychiatrist - stronger leadership required to change cultures of public psych wards Insist that patients have beds for tall patients, obese patients. Increase the activity programs for inpatients. Allow them to have their BBQ once a week that has been suggested by patients numerous times Dignity in dining - melamine instead of plastic box ...a big thing when you can be there for months (enviromentally sound too) Leadership on making sure that young people are not subjected to more ECT sessions than what is in the Mental Health Act . This can happen over successive admissions Improve staff response to and awareness of trauma - especially those who have self harmed, going through psychosis and in high dependancy ward. For example,be aware if a patient has been in seclusion and requires blood tests in low dependancy ward avoid taking them into the seclusion room to avoid re traumatising. Create better communication channels so that when a young person is re admitted the case worker from headspace for example speaks to a ward clinician to provide a sense of the patient and updates. Public campaigns about how friends can support their friend with mental illness - practical strategies and emphasis on speaking to someone, reaching out to show they need that person in their life. "

Is there anything else you would like to share with the Royal Commission?
"Whilst there are many well meaning clinicians and centres for treatment I believe the quality of treatment is problematic. Lack of direction, splintering of services, poor attention to detail and clinical standards means young people in particular receive unhelpful support. Clincians can find broaching the subject of suicidal thoughts confronting and skirt around it in sessions. Promotion and support for clinicians to ask questions to illicit any risky thoughts/behavs should occur in the first session of counselling. There are ways to normalise it to relax the client so that feel it is common...which it is. Early intervention can only be effective with community input, empathy and changing their lense about mental health. Our family member spent a small time of some 5 months in public mental health services - quite alot of it was very distressing for him and us. We know the system let him down despite him being help seeking"