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

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What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?
"Having worked across many areas of mental healthcare in Victoria and with all age ranges I feel that reduction of stigma and discrimination falls to the job of everyone. As a health care professional you can advocate for the people and families of those you work with, but often societal stigma is a much larger beast to slay. I have seen the compounding stigma of mental illness, It begins at the top. Clear messages about what is stigmatising language and why it is harmful to people with a mental illness (as well as other major issues facing people) should be embedded in public service announcements, language guides, and public discourse. Encouragement from government can support this. It is not about destigmatising mental health, it is about breaking the ugly cycle of demonization that occurs when people judge someone by their circumstances. Blaming someone for moral failings because of their mental health, use of substances, housing situation, domestic arrangements, history of abuse, etc is sadly still the lens that many people view those in dire and unhealthy situations. By not having an adequate social safety net for everyone it in turn creates the us v. them mentality and further pushes marginalised people to the edge. "

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?
"The mental health system has evolved well in its inclusion and recognition of a multi-disciplinary treatment team. Reliance on medical staff and indeed a system that revolves around the medical model' of health has been moved away from and has shown positive results for consumers. For some people their mental ill-health does not become apparent until they require the help of acute services. Inpatient units work well to contain someone with a first presentation, but the numbers show that people often return quite regularly after their initial admission. While money has been put into early detection and treatment (Headspace model) there are very many people who come from backgrounds which have poor mental health literacy who do not get sufficient information and support to make informed choices about their treatment trajectory once discharged from hospital. There are some young people who access early psychosis services but in general it is from a hand-picked group who go on to have community follow-up. If there were scope for a stepped approach to community follow-up RECOMMENDATION: Targeting first / initial presentations for intensive follow-up in a systematic way which ensures that it is not a pot luck of how busy the service is when you get ill that determines your opportunities for support. "

What is already working well and what can be done better to prevent suicide?
"I feel that some of the gains that have been made towards preventing suicide are initiatives which have de-stigmatised mental health and have encouraged open and honest conversations about suicide and mental health issues. Working on creating community inclusion around groups that have traditionally faced heavy stigma in society and the media, such as LGBTIQ, non- This has

worked with the general population and people who may experience difficult circumstances, adjustment issues and the with young people especially."

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.

"One of the main issues for people to experience good mental health is the lack of real treatment options that come with the level of support people require to access, engage in and maintain therapeutic treatment. The public mental health sector is set up to deal with Acute presentations and not treatment. While it may have had some capacity in the past, it was inadequate and whatever programs there had been are now largely de-funded as the acute services are stretched due to a lack of places for people to go once they have come out of the Acute phase. People are discharged regularly with no follow-up and when the only housing options they have is a rooming house, homelessness or a dysfunctional home setting it is no wonder that they re-present quite quickly to services. Helping people post-discharge with real support, having local therapeutic services which are tailored to work with people with complex trauma, significant mental health concerns and residual side effects from both their illness and/or medication (lethargy, anhedonia, and demotivation) and can provide them with hope that they can access evidence-based psychological, allied health and holistic services to work through their difficulties is one step forward. When people get discharged with nowhere to turn there are not many service which will assertively seek to support them. Recommendation; review and reinstate assertive outreach teams to support people who disengage from services. "

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?

"Family members can often bear the brunt of the work when supporting PLMI. In my experience these relationships can often be strained by a number of reasons operating together. Paucity of time, especially when the family member is trying to hold down a job while caring for someone with an illness which can be either pervasive or episodic can be very difficult and would require an employer who can support such an arrangement. Recommendation: Make a mandatory pathway for people to access leave arrangements to support family members with a mental illness. An example would the be introduction of the new leave arrangements for instances of domestic violence. Allowing people who are otherwise productive workers to remain in the workforce with periodic support rather make them leave would reduce the amount of people out of the workforce and on a government supplement, both increasing tax revenue and reducing expenditure. There are few services available for family members to get support. More funding and positions for the family-carer mental health workforce and an association of these with each hospital as well as in the community would provide an additional support to a system that is visibly stretched. There are very few workers currently in this capacity across area mental health services and target funding would ensure that the services employ and deploy the staff who hold this knoweldgea rpproriately. With such funding there should be an inclusion for training, clinical supervision and other needs as outlined in the Strategy for the Family Carer Mental Health Workforce in Victoria (2019) "

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

"Working in the public mental health system can be a difficult job. There are many pressures and stressors in the day-to-day work when working to keep people safe and make their lives meaningful. There are organisational pressures like large caseloads, limited time and little if any discretionary funding make doing anything outside of keeping up with basic safety requirements and keeping people well very difficult if not impossible to accomplish given resource constraints. Given this context, there are often not many proven things that invigorate or energise workers or keep their passions about the role and their work high. There are a few things that have had proven results in helping workers feel connected to their clients. Clinical Supervision is one of these things that has been proven to work. Continuing professional development is another. Abilities to grow as a worker and develop and be recognised for expertise is a third. These things should be looked up to continue to be encouraged and become everyday procedure in all levels of the mental health workforce. Clinical mental health staff can have difficulty accessing professional development. In the community high turnover, lack of additional supports like community-based psycho-social rehabilitation and group programs, spaces for people living with a mental illness to engage in activities - these all have knock on effects and make the tertiary/clinical community staff time poor. Their counterparts in the inpatient wards feel similar knock-on effects and when there is little time and a lot to do, professional development, clinical supervision, and individual 'passion' projects get put aside or even forgotten and work turns into drudgery. Additionally the fact that people who enter the tertiary system are often quite unwell by nature, and clinicians can lose passion for the work, and begin to leave the workforce. Having protected time for professional development is not just about learning new information. It is about helping clinicians feel more capable of working with uncertain ideas. It is about introducing and reinforcing directions the workforce should be headed in and which lead to greater understanding, respect and sense of accomplishment for both worker and the people we work with. Examples of this are recovery oriented practice, trauma-informed care, motivational interviewing - professional development that keeps the humanity in the work which we do and rekindles the clinician's passion by helping them connect to the people they work with in a deeper, richer partnership and work towards common goals. There are some things which are working well in the training and development sphere. There are a variety of agencies which provide professional development and regularly update and roll-out new training based on best practice and evidence. But training is not enough. BY supporting workers to take this information back to their workplace and embed it into creating change in their workplace culture and how they as a service work with people, they can bring up the service system. Some current models which support this are the Mental Health Professionals Network(MHPN) and the Statewide Training Clusters. The cluster model has been found to be an effective method of localised education development and has been used in different learning contexts in different countries. It has created goodwill across local healthcare services and creates a geographically-based community of practice that can give people seeking to gain and develop their expertise an outlet and a way to respond to local learning needs. The MHPN works in a way that unites people with similar interest or geographic areas, but is outside of work hours and thus can be difficult to maintain steady attendance. Overall recommendations for this question are: - Protection of time and requirement for health services to allow clinical supervision - Provision of funding and resources for psycho-social community health services to participate in training, supervision and planning activities (currently via the NDIS they are only able to perform duties which are face-to-face) - Retention and funding for MHPN and Regional Training Clusters to continue to produce and deliver specialised training "

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?

"There are many opportunities people living with mental illness could contribute in a meaningful way given the right opportunities and supports. They can be a part of the workforce, visible and proud members of our communities, and meaningful supports themselves for others in the community. What they need is the opportunity to make this happen. Too often mental health reforms have looked at a one-size-fits-all solution, encouraging people to take up this or that program as ways of engaging in the community. There is ample evidence that by providing individualised, trained support for people living with a mental illness to access the right job, in the right environment, at the right time, a fair amount of people living with a mental illness can return to meaningful occupations, paid or unpaid. Employment support programs have been effective when they work with the employer to understand the needs of each individual. This can be done through an employment case manager who works with a limited number of clients to address ready-to-work issues, work on psychological barriers as well as issues which are not so apparent. Some of these include sensory processing disorders, which are shown to be more prevalent in people with mental illness, and communication issues such as receptive and productive language difficulties. An assigned workplace or task could lead to sensory overload or confusion in communication. Providing multi-disciplinary supports such as Social workers, Occupational Therapists and Speech-Language Pathologists can enhance the support for return and retaining employment and are necessary as skilled positions for some members of this cohort from engaging in employment. The nominal added fees of hiring qualified health practitioners in a publicly-funded system and having a work program that is not tied to how many people can be placed in work can either sit alongside current employment services, which often do not take specific mental health needs into account or that is based on placement and not on longevity of outcomes (worker retention). Worker retention can be supported by enhancing supports for workplaces to foster this employment model and like providing opportunities in the way of grants or subsidies with real-world employment outcomes. One aspect of employment and returning people to work who are on government support due to their illness needs to be a removal of disincentives to return to work. If a person goes through this employment program the benefits of work may not be monetary at first and may only incrementally add up to a meaningful and contributing life. It also means that when someone gets a taste of the non-monetary benefits work can bring they may see this outweigh any financial setback by loss of access to government financial support. I would recommend that people receiving a disability support pension get a grace period or a graduated reduction once engaged in an employment service of two years during which they are not threatened to lose their safety net for fear of never getting it back. The system needs ot understand the ups and downs of the diseases it is meant to support. "

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?

"PRIORITIES: 1.More community support programs which are adequately funded. Adequate funding should include face-to-face time as in the current model, AND also allocated time for supervision, management activities and training and education. 2.Increased staff to patient ratios in acute wards in public hospitals. This should include having greater peer workforce presence on the floor and also include drug and alcohol specialists. Greater access to staff will mean more engagement and a reduction "

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
I would think that there are some worthwhile systems and programs in place that are operating well at the moment. Centralisation and divestment from the regions can really take away the unique collaboration and systems that may already be in place which support the ongoing development of the system. Shoring up a psycho-social community mental health system before it and all of its knowledge capitol completely disappear is another quick step the commission should take to ensure more confusion doe snot entail in this already frail secotr

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