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

SUB: 0002.0011.0051

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What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"Improve mental health and illness education and understanding in schools, community groups and adult support organisations (employers, community hubs, hospitals etc). Programs such as live4life in high schools, headspace in schools, Mental Health First Aid, SafeTALK, Wesley Lifeforce training programs etc. Improve health promotion work around mental health and impacts of mental illness in the community. Talk in the community and make a public commitment as a state government/country to reduce suicide rates (such as using advertisements like the road toll related ads). Reduce restrictions on people being able to access services who have mental health diagnoses (e.g. AOD services, housing services, family services). Promote and allow service flexibility to ensure that people with comorbid health issues are seen and supported when mental illness/suicidality is impactful. Improve inclusion of lived experience in education, service provision and leadership around this topic to ensure that personal stories inform practice, education and link community to real life experiences of mental illness/suicidality. "

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?
"Working well: - focus on community based support for those who can manage in the community, rather than institutionalisation. -Holistic care programs such as art therapy, group programs, involving nature and bush work in a mental health setting (minimal funding unfortunately). - Dual diagnosis programs recognising and working with the complexities of mental ill health and people's lives (making waves etc). Not working well: - reliance on carers to fulfil gaps in the service system, impacting on carers mental health and overall family well-being. -Minimal support in the community space with case management for people with mental ill health that is not psychosis/acute suicidality. -Hospital psychiatric unit's being negative and often emotionally dangerous places for those with mental illness/trauma to reside. -Hospital psychiatric unit's only allowing short stays and having minimal after care follow up/program support to integrate back into the community. -Psychiatric triage staff responses varying starkly with some staff refusing support and not trusting clinical decision making of workers calling, and others doing further follow up. - Minimal programs available in the preventative mental health space to avoid acute escalation of symptoms. "

What is already working well and what can be done better to prevent suicide?
"Working well: - Support for community based grass roots organisations around suicide post-vention and prevention is growing via Primary Health Networks, Suicide Prevention Australia advocacy and grants. Place based trials? via Primary Health Networks being a good idea (although not always integrated into the community well with respect for lived experience). Now working well: - minimal follow up programs for people who have had suicide attempts- reliance on the psychiatric triage team meaning poor follow up and people at acute risk not having any

support. -People who are bereaved by suicide and are statistically more at risk of attempting suicide being offered minimal support, information or emotional check ins after a suicide loss. -Minimal societal education or stigma busting work to improve suicide being spoken about publicly and safely. -Poor media take up of Mindframe media protocols meaning that suicide being reported on may refer to method and dangerous information increasing stigma around suicide/potential suicide clusters. -Primary Health Networks suicide trail sites wasting time and money in regional areas because they are not being led by community organisations, people who know the landscape/service gaps and people with lived experience around suicide. -Minimal weight being given to carer's feedback and experience in many settings. "

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.

" -People not feeling heard, understood or being allowed to lead their health care decision making. -People feeling loneliness, disconnected and unable to open up about their experiences due to societal stigma around mental ill health/suicidality. -People getting no follow up, contact, support when this has been promised by a service/person. -People being spoken down to by those around them when in a situation of mental ill health. -Services involved in peoples care not being integrated or communicating to avoid overlap, mixed messages or impactful behaviours. -Stigmatising language used by services, community, health care professionals. -Poor social supports for housing and a high rate of homelessness with terrible support from housing services that is inadequate, and poor personal responses from other services people attempt to gain support from. -Poor social supports via Centrelink that puts people in situations of poverty, high stress and with minimal mental health options. -Capitalist society valuing consumerism, anti-humanitarian sentiment and disconnection of humans. Potential ideas to help improve above: -Care team approaches with integrated meetings, planning and support being streamlined to meet a persons needs in many aspects of life. -Lived experience being at the core of services to ensure approaches are flexible, and funding does not mean that people need to fit into boxes to get support. -Advocate and community development training integrated for staff working around mental illness to ensure they are fulfilling advocacy with their client and carers attached. "

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

'"-Regional/rural areas having poor service provision, long wait lists, long travel times to assistance, poorly trained hospitals and minimal counselling/psychiatric supports in place. This results in less ambulances being available to respond due to having to move people from regional hospitals to regional cities to ensure people can be mentally assessed. -Regional/rural areas having poor transport options for social connection/accessing services or seeking support services needed generally. -Lower socioeconomic areas being under greater stress and services not meeting demand to support people that need it in a variety of areas. -Aboriginal and Torres Straight islander folks being marginalised in policy, government and from historical trauma experiences means poorer mental health outcomes often. This has not been addressed appropriately or fully by our leadership in government state or federal, and minimal lived experience has been integrated into decision making around mental health services for this population. -Asylum seeking people are targeted and offered minimal support by our government, resulting in no monetary support, no support services, no trauma specific support or mental health support. People seeking asylum are made scape goats for political gain, and this results in

suicidality, mental illness and increased trauma impact. People seeking asylum are offered support from non-government funded bodies (ASRC) and partially funded bodies (Centre for Torture and Trauma), however the government has abandoned this community and their mental health. -LGBTQI+ people are marginalised in policy, not adequately represented in leadership or spoken about in a respectful way, resulting in impacts on mental health. Specific support services are in place which is positive, however further advocacy and leadership is still needed. -Older generations of folks have poor mental health outcomes and high suicide rates related to loneliness, feeling undervalued and possible elder abuse. What can be done: -Policy change to reduce systemic abuse of above populations. -Less city centric service delivery and more integrated regional/rural treatment options. "

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

"'-For adequate support to be offered to their loved ones so they dont have to pick up the slack of service gaps. -More assertive outreach/support for carers who struggle to ask for help due to being in caring roles for many years. -More decision making opportunities with their loved one to ensure adequate care is planned for considering impact on carer, family and behaviours not seen by services are known. -Carer support organisations offering practical one-one support including personal therapy and self-care respite options. -Ensuring carers are heard in treatment planning, involved in discharge planning and their perspectives are respected by professionals as a matter of course. "

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

"'-Ensure that work places are supportive to staff with good leadership, adequate supervision and shared responsibility between services supporting consumers. -Ensure that staff have adequate training and growth opportunities to understand and work with complex mental illness presentations. -Create quiet and safe spaces for staff to reflect, debrief and discuss client cases as needed. -Include lived experience of service delivery in leadership decisions in the mental health sector, and share lived experience stories with staff often. -Promote lived experience work within mental health service roles to ensure links between staff, volunteers and consumers and positive advocacy experiences on all sides rather than an us versus them approach. "

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?

"'-Lived experience led organisations being funded and supported to sit in leadership positions with decision making influence, and their time being paid for. -More supportive case management, caring and support programs to increase community engagement, day to day involvement and confidence living in society. -Lived experience being valued and perspectives being paid for to ensure that people living with mental illness are not expected to put themselves out there without support, remuneration or positive experiences. -Consumer participation staff sitting with all organisations as much as possible, and being funded to integrate lived experience in organisations from consultant to leadership functions. "

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?

'"-Post hospital support services which are integrated, community based or outreach based. -Hospital staff having more mental health training to understand lived experience, and not medicalise mental illness without empathy. -Less clinical options for treatment being available from acute settings to community settings (e.g. safe spaces for those suicidal that are not hospital based). -More community based supports that are not psychosis/acute suicidality supportive only. -More outreach and flexible service delivery options in the community. -More preventative education and community work for those who are managing sub-acute mental illness who have potential for this to escalate without adequate support (e.g. focus on well-being programs, holistic loneliness remedies via community programs etc). "

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

'"-Ongoing review and systematic lived experience involvement at all stages. -Rebuilding mental health services from the ground up, with minimal loyalty to old systems that are in a state of dysfunction. -Ensure that a good PR approach is taken to the money and effort being put into this changed system, ensuring the community is aware of how essential mental well-being is to all of us, and how important this is to get right for our communities (to avoid expenditure backlash from community). -Integrate lived experience and feedback opportunities in real ways into the reformed/new system for mental health services, to ensure that people and systems are always held accountable in real ways, and can be forced to change as needed. "

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

"Too many times as an advocate working in a variety of spaces my clients have been turned away for not being unwell enough, for not being at risk enough or psychotic enough. When drug and alcohol are involved, it is as if many mental health services assume AOD services can solve all the problems for someone and that because someone is using, they dont deserve the mental health support they so greatly need. We are all supposed to be dual diagnosis capable, however it is an ongoing frustration within the AOD sector in particular that we come up against road blocks and minimal options for our clients with mental ill health and AOD issues. No AOD rehab will take clients with unstable mental health, and many mental health services are apprehensive about taking AOD using clients. Even dual diagnosis rehabs that have recently been established have now stated they want people to be stable in their mental illness- which is up to their discretion to decide. There are minimal preventative options for people to avoid them getting unwell to the point of being unable to function, which puts more pressure on our mental health systems than is necessary in the long run, particularly hospitals with minimal training in mental illness, behavioural management or suicide prevention- and with poorly trained security guards. Additionally, suicide prevention is underfunded, poorly understood and medicalised to the point of losing all humanistic approach in acute settings often. I have personally and professionally heard many stories of supposedly flexible services such as [redacted] and [redacted] health not contacting families or young people when they say they will, or turning young people away- those young people have eventually suicided without support. Opening another head space centre, instead of funding outreach, more flexible non centre based supports, seems counter intuitive at this point. I have heard client stories from those dealing with homelessness (a highly stressful and mentally impactful experience) where they have been told to simply get a job to find housing, and not offered any alternative support, information or avenue to explore their options from housing services. This sounds to be lack of mental health understanding, training or supervision in the housing space I believe in addition to the same under resourcing pressures put on many systems.

Working voluntarily in suicide prevention in my regional community i hear stories often of locals being turned away from our [redacted] hosptial because they are ""too unwell"" to be helped, when mental illness is involved. People are sent to Bendigo, an hour away, for any support or mental health assessment. This is despite the fact [redacted] Hospital staff have now been trained in mental illness and are supposed to be mental health assessment capable with video link to [redacted] Hopsital. This results in highly vulnerable people being sent on a wild goose chase to get support, an hour away in either direction. Additionally, our community health services have to fight for funding yearly to get staff as counsellors, AOD workers and mental health professionals, and none of the support from government funding wise allows ongoing planning of consistent workers in roles locally. There are many issues with our mental health system, in the cities, but particularly in regional/rural areas. "