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

SUB. 0002.0028.0072

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"There are many organisations currently working to improve knowledge and attitudes to reduce stigma and discrimination. Organisations such as Beyond Blue appear to be doing this well and it appears that since its inception Beyond Blue has led the conversation about mental health. I feel that this has seen a dramatic impact in the last twenty years but still much more is to be done. Attitudes take a long time to change, and behaviours even longer. I think investing greater in organisations such as Beyond Blue to continue to do what they are already doing is a great start. One of the reasons I think they do so well is because of their community presence and I think it is best to leverage this and invest greater in these organisations to reach further across Victoria. I think this idea of community presence could be replicated by many mental health services including tertiary mental health. Engaging the community through attending or hosting events (like Midsumma) will not only help to reduce stigma and discrimination but also build mental health literacy and relationships between mental health services and the general public. This would, in turn, increase help-seeking actions and early intervention. "

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?
N/A

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.
"NB - This response is a duplicate from question ""Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?"" as there are many cross overs between the questions. Having worked as a mental health nurse for 10+ years in clinical community mental as well as 2 years recently in the health promotion sphere, I feel that a great deal needs to change. 1. Currently area mental health services (AMHS) have very different ways of delivering the care that they give with little or no standardisation between services. What this means is that a person who lives in Hawthorn will receive entirely different care when they move to Melton for example. I feel this is because each mental health organisation/ public hospital overseeing the AMHS has the ability to make their own changes to the service and decides what to do with additional funding with no need for community engagement on these decisions. An example of this would be some AMHS having a CATT (Crisis assessment and treatment team) whilst others do not. An ideal system will have an body that oversees all the services and ensures that they all provide the

same, evidence based services. 2. Some AMHS have integrated mental health teams which means that quite often clinicians are working between acute and case management functions. This appears to be an evolution of the previous system where there were three specialist community mental health teams (CATT, MST, CCT) depending on the acuity of the patient. What this means is that in the new system clinicians are unable to be contacted on several days in the week and therefore consumers of that service will no longer contact when in crisis. In my opinion, this has drastically changed the ability to develop relationships with clients and in this field relationships are of paramount importance. This is possibly a good example of the move of AMHS from being a proactive service (enabling support and assistance to consumers) to being reactionary (seeing people when they reach crisis). 3. Having worked at a PHN (Primary Health Network) for some time recently I have noted that not all commissioning decisions are made in consultation with local communities. For example, organisations that are good advocates for their communities and that have extremely good relationships with executives tend to receive better funding opportunities despite recommendations of the workers and communities. I feel that this could be helped by having greater oversight of the activity of PHNs and Mental health providers or even better, having one body in Victoria to commission and fund all mental health services (psychosocial, clinical/tertiary etc). This might mean removing the PHNs from the commissioning of mental health services but the benefit is a far more equal world without duplication of services. 4. I would like to see localisation of services in Mental Health Hubs across the state, much like what is being achieved in the Orange door locations for the family violence sector. I think local communities should each have their own hub that acts as a drop in centre, that has both clinical and psycho-social mental health services, NDIS providers as well as services that address the social determinants of health (Housing workers, employment specialists etc). These centres should be not confronting or intimidating, a place where people can retreat, with a staffed cafe or similar as a drop in (like the current studies being done on benefit of mental health cafes) which can offer an alternate to the emergency department for those in crisis. Having all possible services in one place could assist in the integration of services and to further aid in this, each centre could have one manager to oversee all the services ensuring seamless integration. Furthermore, peer workers could provide a great service in these centres to act as service/centre navigators and join the consumer on their journey in the centre. "

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 opinion there are many factors that contribute to this. In summary I would suggest that these are topics already identified by the Royal commission and include; a disjointed, difficult to navigate and poorly developed mental health system, stigma and discrimination, lack of early intervention and primary prevention. Many of these i have covered in other areas of this submission. One other, less spoken about factor I have experienced as being a contributor to poor mental health is the Workcover system. The way this system treats people presenting with mental health difficulties and psychological distress can be done better. Some examples of poor treatment: 1. I had to take leave from work following a serious assault by a patient when I worked on an inpatient unit. For my workcover claim i was required psychiatrist for taking less than two weeks off work and where the assault had taken place in a mental health unit by a patient where i was a nurse.This lack of trust for me to identify my own psychological need made me feel that this system had no understanding of me as an individual and the context of my assault. 2. My mother suffered an accident during work which led to several health and mental health complications later in her life. As part of the review process she would have to see a Psychiatrist on a regular basis. Most would have different views on her treatment and diagnosis and ability to remain on

Workcover payments. There were times where she wasn't afforded the opportunity to speak and the Psychiatrist would come to conclusions that supported Workcover's want to take her off the payments without proper review. This was also a common theme with patients I have cared for over the years where it appeared as though there may have been bias in the Psychiatrists doing assessments on behalf of Workcover and the outcomes of poorly conducted assessments supporting Workcover's intentions. 3. Over the years I have cared for many people involved in this system that feels like it automatically treats people as though they are rorting the system (as though they are guilty until proven innocent). This has led to a worsening of mental health for the people including increase in suicidality in this population. I would be interested to see data on people who are involved with Workcover who attempt suicide or take their own life and I would not be surprised if this is a greater proportion than in the general population. To address this i would recommend better oversight of this system and an investigation into the ways Psychiatrists employed by Workcover are being compensated for their assessments. "

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

"I think for the current system, it is difficult for families to express their concerns. This is particularly apparent when their loved one with a mental health condition is refusing mental health treatment and they do not meet criteria for involuntary treatment. I have seen this on a regular basis, families are scared and feel powerless to be able to help their loved one and if their illness has not progressed to the point of them being a risk, then clinical services will not intervene. I am aware of the complexity of this issue when enforcing treatment on someone is not the best option and building insight for an individual can take some time. This could be achieved by earlier intervention and the building of better relationships with the clinical mental health sector and the community. When mental health services have more opportunity to be proactive, then they will be able to invest in building relationships with people at risk and those exhibiting early signs of mental health conditions. Families need to know that they are being listened to, that their loved one is going to receive the right care at the right time and that they know exactly what services are available and how to navigate these services. This could be addressed by localisation of services in Hubs where multiple services (Clinical mental health, psycho social support, housing, employment, General Practice) are all available to someone as a drop in service, similar to the Orange door safety hubs currently being rolled out in Victoria as part of the Family violence royal commission recommendations. "

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

"I think the response to this question is multifaceted and almost too complex to answer. As a nurse who has moved outside of the clinical sphere to move into health promotion these are some of the issues influencing my change: 1. The system needs to be redesigned. Working in the system at the moment causes people who are truly passionate about this work to leave after a short while from experiencing compassion fatigue and burnout. People who are initially attracted to these roles are compassionate, caring individuals and they want to make a difference. In the system, as it is at the moment this does not feel possible and people working in the system become disillusioned. The system at the moment appears reactive and crisis focused, rather than proactive and preventative. 2. There appears to be a culture of blame in the system, this needs to be addressed. There is an automatic assumption that people are doing the wrong thing instead of supporting people through clinical decisions. I'm not sure where this stems from; whether it be risk

aversion or the fact that some (not all) senior people in the mental health sector are left over from Asylum days and therefore hold antiquated views and management practices from this time. Better support and people management would help in this. 3. The physical environment appears old and antiquated and needs to be updated. Many of the buildings have not been attended to in years and as an environment it directly impacts on your own mental health as well as that of consumers. Thinking of my experience working as a mental health Nurse overseas, people were much more likely to want treatment and attend outpatient aftercare when the environment appeared more soothing, professional and focused on recovery. 4. The system keeps changing with what appears to be motivations based on funding and this needs to be addressed. An example of this is where a major tertiary mental health system went through redesign. This resulted in no intensive support team and staff rotating on a daily basis through separate functions (crisis and case management), giving them less days to look after the same number of clients (some people still have case loads of 22 clients on two days a week of case management which is alarmingly high). This redesign took away workforce focus on clients, preventative care and building relationships and placed in solely on reactionary work ""putting out fires"". 5. The workforce need to have greater input into the system and decisions need to be taken out of individual service's management hands. A perfect example of this is recent extra funding given to an AMHS for extra staff. Instead of consulting with staff or the community about how to use the funding, management of these services have decided this alone without making an evidence based decision. I would recommend greater oversight of these decisions and perhaps a governance group of workers and people with a lived experience to oversee decisions made by individual health services. 6. I almost hesitate to say this but I think pay needs to be better for people working in clinical mental health services. The pay discrepancy between mental health nurses and psychiatrists is major and this is alarming when considering the roles, risks and responsibilities are not that dissimilar (aside from the prescription of medication). As a mental health nurse sitting with risk on a daily basis and all the associated stress that came with this, I did not feel that the pay difference between Psychiatrists and other mental health professionals was justified. "

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?
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means that quite often clinicians are working between acute and case management functions. This appears to be an evolution of the previous system where there were three specialist community mental health teams (CATT, MST, CCT) depending on the acuity of the patient. What this means is that in the new system clinicians are unable to be contacted on several days in the week and therefore consumers of that service will no longer contact when in crisis. In my opinion, this has drastically changed the ability to develop relationships with clients and in this field relationships are of paramount importance. This is possibly a good example of the move of AMHS from being a proactive service (enabling support and assistance to consumers) to being reactionary (seeing people when they reach crisis). 3. Having worked at a PHN (Primary Health Network) for some time recently I have noted that not all commissioning decisions are made in consultation with local communities. For example, organisations that are good advocates for their communities and that have extremely good relationships with executives tend to receive better funding opportunities despite recommendations of the workers and communities. I feel that this could be helped by having greater oversight of the activity of PHNs and Mental health providers or even better, having one body in Victoria to commission and fund all mental health services (psychosocial, clinical/tertiary etc). This might mean removing the PHNs from the commissioning of mental health services but the benefit is a far more equal world without duplication of services. 4. I would like to see localisation of services in Mental Health Hubs across the state, much like what is being achieved in the Orange door locations for the family violence sector. I think local communities should each have their own hub that acts as a drop in centre, that has both clinical and psycho-social mental health services, NDIS providers as well as services that address the social determinants of health (Housing workers, employment specialists etc). These centres should be not confronting or intimidating, a place where people can retreat, with a staffed cafe or similar as a drop in (like the current studies being done on benefit of mental health cafes) which can offer an alternate to the emergency department for those in crisis. Having all possible services in one place could assist in the integration of services and to further aid in this, each centre could have one manager to oversee all the services ensuring seamless integration. Furthermore, peer workers could provide a great service in these centres to act as service/centre navigators and join the consumer on their journey in the centre. "

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

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