

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

SUB. 0002.0028.0474

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

N/A

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.

N/A

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 would be better supported by the system if consumers were encouraged to do the following things: - have an Advanced Statement that the carer knows about (if the consumer wants them to know) and is lodged with the hospital and taken into consideration when the person is hospitalised. I have heard lately that hospitals are not keeping Advanced Statements accessible and in the system so the statement is not being considered. - have an appointed Enduring Power of Attorney for Financial Matter and Personal Matters (not necessarily the carer) -to ensure people hospitalised are not taken advantage of by other people (e.g. other family members/visitors). - have a Nominated Person (not necessarily the carer). Hospitals need to follow the Chief Psychiatrist Guidelines of contacting the Nominated Person and consumer identified Carers whenever there is a restraint (physical, mechanical, chemical) or seclusion (or any restrictive intervention) used on the consumer. They also should be contacted immediately and invited to visit the consumer while the intervention is being used or as soon as they can get there regardless of normal visiting hours. In addition, visiting hours should be as broad as possible and should be overridden if there is an urgent need for the consumer to see their carer or other specified visitor."

What can be done to attract, retain and better support the mental health workforce,

including peer support workers?

"There should be different types of peer worker roles that account for the fact that some peer workers have specific and useful qualifications and their title should reflect that. For example, there should be Peer Support Counsellors, Peer Support Social Workers, Peer Support Psychologists, Peer Support Psychiatrists etc etc. Then people can use their mental illness lived experience in their role and with their consumer clients as well as being recognised for their qualifications and other experience related to their qualification. The term Trauma-Informed Peer Support Worker is a good title that reveals extra training and/or qualifications of the consumer worker but I still think that specific terms such as 'counsellor' 'psychologist' etc are good to be included in the title for some peer work roles. I know there is a view that peer workers should not be clinical but what that is doing is making people with a mental illness and a relevant mental health qualification either just working as an ordinary 'counsellor' or 'social worker' etc without being recognised as a consumer or using this part of their experience - their lived experience - expressly in their role. The other thing that happens is that that person takes a role just called Peer Support Worker or Consumer Consultant, leaving their qualifications as dormant and out of the picture. What they could do being a Peer and a professional combined is lost whereas they could be doing broader and more holistic work. Thus clinicians who want to be known as a peer as well, instead of staying just clinicians, could have this opportunity and they could imbue their lived experience into the role in ways and with such a different and greater impact on mental health of the people they help that is currently uncharted territory. Completing an education in Peer Work, Mental Health or AOD should be free for mental health consumers whether this is at Tafe or University Level. Other related areas such as psychiatry, counselling or social work should also be free for mental health consumers. Then we can have more Peer Support Counsellors/psychologists/psychiatrist etc etc. The reason education should be free for consumers is because a lot of consumers feel unable to work full-time and will not meet the threshold income upon which contributions to the HELP Debt is taken out. Because of this they will just have a HELP debt hanging over them for a very long time, maybe to only be deleted once the person dies - it is not good to have a debt hanging over you that also gets indexed each year (i.e. increases even though there is no formal interest). "

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?

"As stated in the answer to the last question (please see above) - people with mental illnesses should be given free education if the education relates to an area of work that is needed by the mental health system such as Counselling, Social Work and even Psychiatry but especially Certificates (1,2,3,4) in mental health, drug and alcohol, and peer work. As some or many people with mental illnesses may never work full-time or at a pay rate high enough for the HELP debt to be paid back in the normal fashion, they may have their debt (if the education is not free) hanging over them for a long time and this debt keeps getting indexed and hence getting higher every year. This may not be the situation of many consumers so I don't want to make assumptions in my last statement but this statement is true for me - now I am on the DSP and have a huge Help Debt that keeps getting higher each year by being indexed and is going to take me a while to repay. Basic courses, for example in computer skills, should be free for mental health consumers and other people at a disadvantage. More peer work and consumer roles overall will help the economic participation of people with a mental illness if they are interested in working in mental health

services. "

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?

"In inpatient services: - Nurses and doctors should be out an about interacting with consumers, not hiding behind glass offices and writing notes. - Notes should not be written without the consumer, the consumer (unless completely incapacitated) should be part of the note taking process - There should be notes about the consumer's recovery: the recovery model should always be used. - Thus instead of being behind glass in offices writing notes the worker could be sitting out with consumers engaging them to write their own notes or notes collaboratively with the consumer. That is, this note taking could be a vehicle for greater interaction with the consumer and would help them understand more about what they are experiencing or what is happening to them and why while they are in the hospital and how the staff are perceiving them. - Advanced statements should be readily accessible to staff in inpatient services and taken into consideration by all staff. - All the Chief Psychiatrist Guidelines should be followed not just when and where convenient or easy. - Nurse and doctor whistle-blowers: staff of hospitals should have an easy and confidential way to report services that are not providing the optimal level of care - they should report any and all practices that they observe or are made part of that do not adhere to the legislation and/or the Chief Psychiatrist Guidelines. Thus there should be a dedicated organisation for hearing the accounts whistle-blowers. For example, an area/team within the Mental Health Complaints Commissioner dedicated just to hearing from nurse/doctor/peer worker whistle blowers that keeps them anonymous (if they want to be) and responds appropriately. Breaches of the legislation, such as what whistle-blowers may report, should be treated very seriously and the service or worker that has made the breach should have certain serious consequences that ensure that the behaviour never happens again. A breach for a second or third time should result in the worker no longer being able to work there or at any mental health service or for a service to make immediate and lasting changes to their service. "

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

"It takes a long time for consumers to become engaged in services and to fully interact with that service. Thus major services changes (i.e. the elimination of services and implementation of new services) are detrimental to people and I think this is especially true in the mental health space. This is because a lot of people with mental illnesses have insecure attachments due to difficult upbringings and maybe also neglect and abuse. This makes it hard for them to feel secure and comfortably interact with new services and the new workers. Trust and safety are key attributes that services have to foster over a long time period - and we all know the benefits of fully formed therapeutic relationships. You take away a service that people trust and they may not want to start the whole trust building process again with a new service or worker. They could be impeded in doing this for a long time. Therefore for improvements to last there actually should not be too many changes to services or this should be very gradual with the goal of getting people involved in the new service way before the old service - the one they trust and has been therapeutic to them - ceases to exist. This is a way to prepare for changes, it is just that - fully prepare consumers for changes by having an overlap of new services with the old even if this is costly or otherwise hard to achieve. "

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

"I want to share that I am very disappointed with the questions that the Royal Commission has asked. I don't know why there is no question dedicated to restrictive interventions when this is a point of issue for many consumers I have ever spoken to. I think the commission should have asked about people's experience of the treatment in inpatient services in particular and asked to describe experiences of negative treatment by certain nurses or doctors or the service as a whole. I think the individual experience of inpatient services should have been explicitly included so people have a space to share what might have been the most harrowing and frightening experience for them in hospital. Questions like 'has a mental health worker or service ever caused you harm and what was this harm?'. If I haven't already said so I just want to say that having your hands and legs strapped down to a bed is one of the most degrading, frightening and inhumane (breach of human rights) experience and people need to be debriefed afterwards and carers and nominated person should be called to be with the person during restrictive interventions and included afterwards in the debriefing if the consumer wants. "