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?
"The overwhelming majority of those who experience MH issues do so privately, even those that experience profound mood or psychotic disorders are more likely retreat into more reclusive existences, mostly out of sight of the community. The people who are most likely to create stigma are those that choose to behave in an antisocial and violent manner. It is this very small cohort that exists in Area Mental Health and Forensic MH services and at time publicly in communities, with their volition for violence, that disproportionately create the most amount of trauma and stigma. Regardless of metal illness everyone knows right from wrong, not least of all this group of people just mentioned, impinge their sensibilities in any way, they are very quick to inform others of their rights and how they are perceived to be discriminated against. The issue of intent also parallels that of non mental health sufferers, intent can be either interpreted as malicious and entitled behaviour or a result of fear and perceived need protect self or others. Intent is an indication of a persons core personality and beliefs, not an indication that they are mentally unwell or not. In my experience, Psychiatrists are all too often ill equipped to make this distinction, when recommending to our Judicial system a mental health defences. This observation can be evidence by the the pre-trial hearings of the Bourke St incident accused, were the opinions of 3 esteemed Psychiatrists arguing for a MH defence, was over ruled in favour of the extensive interviews and assessments by a renowned Forensic Psychologist to the contrary. No-one including myself disputes the need for adherence to Universal Human Rights, particularly those that pertain to sufferers of Mental Illness, however equal adherence to the rule of law must also be respected, with its' resultant consequences, that can foster empowerment though individual responsibility. Ways to ensure this is to implicitly enshrine the concepts of mutual respect and responsibility which underpin the Safe Wards model of care being implemented in our inpatients services. That community expectations are adhered to within our MH services, particularly inpatient and that natural consequences are sort when theses expectations are not upheld. It is pointless to articulate a 'Zero Tolerance to Violence' when there are no consequences to enforce it. This issue is of particular concern in Forensic inpatient services where physical assaults on MH workers is increasing. Fear drives stigmatisation by our communities and it is an incredibly small percentage of MH sufferers that behave in a manner, that disproportionately validate that fear. Consumer Advocate organisations like [redacted] need realise that, instead of being divisive and characterising MH workers as thugs, because of the legitimate use of restrictive interventions and involuntary treatment regimes. Mental Health worker don't create the violence, they react to it. It would be fantastic if the like of [redacted] decided to be more collaborative in their approaches to improving MH outcomes for consumers. Sent from my iPad"

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?
"What is working well within our MH services, is our frontline MH personnel. Their resilience,

adaptability and dedication to their roles, despite some of the most demoralising and traumatic circumstances is in my opinion awe inspiring. The presence of a specific MH workers Union HACSU, has also ensure MH service are even more in disarray, as it has been this Union along with its' members that have lobbied and successfully fought against more closures in our Community MH services and for increased staffing, capital investment and safe working structures within inpatient services. I am more than happy disclose i am a proud long term HACSU member and workplace delegate, however this submission is purely my own. What is required is greater funding and development of community base MH services, as well as better education and support of General Practitioners to support consumers to remain in their communities and avoid more severe relapses in their illnesses that would necessity hospitalisation. That consumers suspected of drug and alcohol intoxication, be assessed separately and treated to ensure these episodes and lingering effects are resolved, prior to any MH assessments being conducted and being admitted to MH inpatient services. Reducing demand on inpatient services, will ensure longer inpatient admissions can be made available to consolidate recovery outcomes."

What is already working well and what can be done better to prevent suicide?
"In recent years more transparent reporting of suicide in our media and the presence of Beyond Blue has assisted in the destigmatisation and community awareness of suicide. LifeLine has also provided a crucial first contact, crisis service, however more preventative initiatives are all but non-existent. Whilst better than nothing being, the ability to acquire a mental health plan to access subsidised psychological intervention is inadequate, as the number of sessions is capped at 10 sessions. For many, 10 sessions would only be consider akin to just opening the can of worms, once open it can't be closed. The ability to access subsidise intervention should be extended, if not made open ended depending on individual circumstances. Applied Suicide Intervention Skills Training as used by LifeLine staff should be funded and made more widely available to all health services staff and first responder personnel, as well across out education system, to lessen the onus on those struggling with life circumstance having to seek help. Greater awareness and research is required in the areas of social isolation and particularly 'Loneliness', which is now being described as an epidemic that not only contributes to depression, but also can have detrimental physical health outcome. Legislators need to be more accountable for and made to place emphasis on in-depth assessments, regarding the social impacts of proposed policies that could result in detrimental MH outcomes, as they do budgetary/financial and environmental aspects. Particularly when these policies relate to a reduction in Community support services, impact on employment without providing transition plans and structures for displaced workers or that greatly impact peoples general lifestyles and enjoyment of life."

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.
"The lack in presence of community assessment and outreach services, greatly diminishes people's access to seek adequate help for MH issues within Melbourne metropolitan areas and is further exacerbated by the social and geographic isolation of those living in more provincial/rural areas. The ability to access and build rapport with GP's for the purpose of referral to ongoing MH intervention is also of concern. Long term compliance with treatment is of great concern, as some may not seek Inpatient care for acute MH episodes due to concerns for their safety. MH treatment/care is too heavily weighted towards Medical Models of care that are reliant on pharmacology, which may work well for significant affective and psychotic disorders, however can

be ineffective or detrimental long term when dealing with reactive, stress/anxiety and trauma related MH issues. Even if people are able to access MH services, they may experience waiting list for ongoing community follow up, due to chronic understaffing and excessive caseloads or inpatient treatment may be of too short duration and not adequately individualised to consolidate recovery and ongoing positive health outcomes. Long term continuity of engagement and treatment compliance may also be impacted as a result of poor staff retention rates. Again, greater emphasis, funding and development of Community services and support will go some way to improving MH health outcomes, however greater focus on developing social cohesion and than division is ultimately required. It is all well and good for politicians to promise funding for prevention of suicide, but if that funding does included investigating and combatting the circumstances that lead people to such levels of MH distress, then that increased funding will achieve very little. Often it is policy decisions and the legislation they lead to, that create great level of MH distress in our communities, particularly legislation that exacerbates social isolation and inequality."

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

"Along with social/geographic isolation and loneliness, intergenerational disadvantage, abuse and inequality, with resulting trauma and feelings of hopelessness is of great concern. Trauma experienced by migrants is never fully acknowledged, particularly those that have arrived here seeking asylum from conflict, tyranny and persecution. Our First Nations people are still all too commonly spoken at rather than genuinely consulted with and listened to, about their needs and aspirations and discovering how they communicate and interact within their communities. Divisive commentary from our Legislators, Peak Institution lobbyists and various media outlets, consolidates and amplifies the level of MH distress experienced in these communities, which also incorporates the LGBTIQ community. Greater courage is required to identify and call out discriminatory and vilifying commentary and acknowledging that the general poverty of empathy in our communities is as serious an issue that needs to be address as is domestic violence and violence in general against women. More empathetic communities are more likely to support and care for our most vulnerable, none the least of those being sufferers off mental illness. One strategy could be implementing the wider uptake of ASSIST training in our communities, as people can only be effective with these strategies, when they are attuned to listening to the stories and experiences of others, to be able initiate intervention. "

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

N/A

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

"In the short and long term, of paramount importance is keeping MH workers safe in order to retain the staff we already have. MH workers are as much victims of trauma within our MH services as any consumers, not only as a result of individual violent incidences, but also the compounding, longitudinal effects of constant verbal and emotional abuse. Within Forensic MH services I have worked, I have been witness to and aware of far too numerous physical assaults, including sexual assault. The occurrence of verbal abuse and sexual harassment is constant and I have no reason to believe similar levels of abuse are not common across most MH inpatient services. Staff have

next to no level of recourse in these circumstances, any attempt to pursue legal recourse is ineffective and ultimately demoralising. The presence of any Work Safe oversight is next to non-existent with regard to workplace violence, outside of major sentient incidences occurring. Even when they have investigated major incidents, particularly on one unit i have worked, their approach was lack lustre to say the least and totally missed the reasons these incidents occurred in the first place. When staff have been assaulted there appears to be an Industry wide arrangement where, 'Special Leave' is utilised for recuperation, rather than workers accessing Work Cover. The perception is this is a practice utilised by employers to circumvent increases in insurance premiums and possibly avoid Health Department scrutiny. Work Safe have been made aware this occurs, however are unwilling to do anything about it. Even our incident reporting system RiskMan is an opt in system with regard to logging incident as OH&S in nature, which I believe is ridiculous in itself. I have spoken with many newly qualified post graduate nurses within my workplace and a number have presented as demoralised, possibly more than I am after 25 years working in MH. They expressed already feeling trapped, after spending 3 years undertaking a Bachelor of Nursing and 2 years attaining a Post Graduate diploma in MH, in a career that is toxic to their own MH and extremely dangerous. They feel they are not being adequately protected by their employer and don't see circumstances being any better elsewhere. Nothing in the undergraduate training of nurses, prepares them let alone suggests the realities of working in MH. What needs to occur in the short term is that any further investigation of Restrictive Interventions, particularly as they pertain to the reduction in use of seclusion be ceased, until proponents of such measures adequately investigate tangible alternatives that are proven to maintain the safety of MH staff. MH staff do not utilise seclusion as an easy way out or respite from disruptive patients as some attempt to characterise. In reality maintaining someone in seclusion as per necessity and adherence of the Mental Health, is often more perilous to MH staff. That a system of workforce welfare, support and/or peer mentorship should be created and implemented. This would fill the void between Clinical Supervision and reflective practice and employers outsourcing their duty of care for employees by referring them to Employee Assistance Programs, when employees are experiencing acute distress. Those tasked with providing this support, should also be trained in Applied Suicide Intervention Skills Training. WorkSafe to be directed to play a greater role in reducing workplace violence and WorkCover to investigate employers circumvention of injured worker protections. Also WorkCover itself to be referred for investigation regarding its regime that financially penalises injured workers, that exacerbates mental and emotional anguish and may protract injured workers recuperation or induce them to return to work before they are emotionally capable or prepared. That a dedicated secure containment service be commission to contain physically abusive patients, this may include Forensic Patients that are physically abusive and not complying with a rehabilitative process. That specialised undergraduate training of mental health nurse be reinstated and/or a dedicated cadetship system of training be implemented, that can use to stream enrolled nurses and allied health professionals (including Psychiatric Services Officers) into MH specialisation. That there be a doubling of Psychology staff within Forensic services to ensure recommendations arising from assessments are acted on and implemented. That an independent body be created to investigated incidents within mental health services, rather than allowing health services initiate investigations themselves. Lived Experience Peer Support Workers to my mind already have ample support in their roles, they have also been offered support and representation by HACSU, which to my knowledge very few access. "

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?
"The restitution of MH service networks independent of General Health service networks. Mental Health services require their own funding allocation and governance structures, that are separate from overall health budgets. Since de-institutionalisation where MH services were transferred to larger general health networks, already underfunded MH services have been used to prop up other non-mental health areas of these networks. This has resulted in underinvestment in inpatient beds and of most concern underfunding and cutbacks in Community mental health services. It also has flow on effects into our Criminal Justice/Corrections sectors and the area I have worked within for over 20years, being the Forensic Mental Health sector. Since deinstitutionalisation our Criminal Justice/Corrections sectors have become significant catchment services from those experiencing profound MH issues, to the point our Forensic MH services are well past capacity to offer safe and adequate service delivery. In the short term major investment is required to commission a new facility, specialised in the treatment of security patients who are under sentence in our Corrections facilities and funding to restructure Thomas Embling Hospital to make it a dedicated Forensic Hospital for the rehabilitation of Forensic Patients that incorporates gender specific rehabilitation streams. Concurrently major investment is required to re established and expand Community Assessment, Treatment and Outreach services to ease pressure on Inpatient Services, as well as attempt to prevent people entering our Criminal Justice/Corrections services."

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
"Trauma spectrum disorders will comprise a significant proportion of Mental Health disorders experienced into the future. MH workers themselves may well present in increasing numbers for MH assistance as a result of trauma experience within the workplaces, hence the need for workplace welfare and support services. Trauma intervention and support is already needed for our first responder and emergency service staff, as well as ADF personnel. Domestic Violence and many other forms of criminal abuse result in trauma and the effects of trauma is most certainly present in people who migrate here, particularly those seeking asylum who come escaping conflict and tyranny. Trauma transcends all aspects of our community and often is a precursor to many other MH concerns. Despite the prevalence of trauma, very little if anything is still being done to deal with it. As such, much greater funding needs to be allocated into the research of Trauma related disorders and treatment systems developed before it presents as an overwhelming area of MH disorder. Immediate research and assessment is required into current MH workforce well being, to ascertain and implement appropriate care and support is implemented, to ensure workforce retention."

Is there anything else you would like to share with the Royal Commission?
"Much of what is being experienced within our MH systems was foreseen long ago, MH service administrators have wilfully ignored concerns, they have neither adequately advocated for or protected their employees, let alone lobby for adequate services for consumers. It was fore warned the abolishment of MH specialist nurse training would lead to an eventual staffing crisis, instead offshore recruitment was sort, however even that avenue is now drying up. MH service administrators have been aware of the increasing violence experienced by MH staff, yet have

done very little to combat it. That the incidence of suicide among MH workers is all but non-existent is remarkable and testament to resilience of MH workers, however I am extremely concerned that resilience will be increasingly tested if circumstances do not begin to improved soon or that a fatality/fatalities will occur. MH workers are generally very apathetic about the prospect of meaningful improvements occurring within our MH system. This can be evidence in their ambivalence in completing the annual People Matters Survey conducted by DHHS, particularly by clinical services staff and require a great deal of encouragement/coercion to participate, as despite their input they feel they don't perceive meaningful if any organisational or systems change."