AUSTRALIANMENTAL HEALTH CONSUMER NETWORK

August 6, 2007

The Secretary
Senate Community Affairs Committee
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Sir or Madam:

The Australian Mental Health Consumer Network hereby submits the attached document for the consideration of the Senate Community Affairs Committee in its Inquiry into mental health services in Australia.

Because our local area network has been malfunctioning, I am not able to send this submission on AMHCN letterhead, but will send a more formal copy when we are able to do so.

Thank you for your consideration of our submission.

Sincerely,

Jenny Speed
Deputy Director
On behalf of Helen Connor
Executive Director
Australian Mental Health Consumer Network

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Promotion, Prevention, Early Intervention

While the philosophical framework agreed to by the Council of Australian Governments identifies building resilience and coping skills in children as an important policy direction, the individual state and territory plans focus on identification of illnesses in children. While this is important, care must be taken to avoid the medicalisation of behavioural issues. There are already parts of Australia where the volume of psychiatric medication prescribed for children exceeds international norms. While this can be a cause of strain on the Pharmaceutical Benefit Scheme, of more concern is the long-term impact of continued use of medication on children. It also does nothing to strengthen the capacity of children in general to deal with the events confronting them that may be a cause of trauma or distress.

There are programs available which have been demonstrated to be effective in building resilience which can be delivered in schools or in non-educational settings and which deliver a generalised benefit to the whole community.

The expansion of suicide prevention programs is an important issue, however programs and interventions need to be specific to particular locations and communities. Some indigenous communities, for example, have dramatically reduced the incidence of suicide through the introduction of programs developed within those communities.

It is also important to recognise that other forms of self-harm can cause long term, possibly lifelong, disability and are indicative of extreme distress. These also need to be included in the general approach.

Research amongst young people has demonstrated their reluctance to present at general mental health services. More emphasis needs to placed on developing models of service delivery that are accessible for and appropriate to young people.

Research initiatives need to investigate innovative methods of service delivery as well as bio-pharmaceutical issues. While symptom control is of great importance, the ultimate goal of the mental health system must be to assist people to resume meaningful lives, and the impact of current approaches to treatment often fails to enhance that potential. Indeed, it is sometimes detrimental to it.

Call centres are a useful addition to the mental health system in so far as they provide access to the system at all times and in all locations, but they can only be effective if there is the capacity within the system to provide substantial support to callers. People ringing call centres have to be given timely and accessible options to have their needs met.

Integrating and Improving Care System

The formal component of the mental health care any person receives is only a fraction of their overall care. They might see a psychiatrist once a week, or even less frequently; they may have a weekly appointment at a mental health service. But their mental health needs are continuous and affect all parts of their lives. Integrated case management must address the range of needs people with mental illness have, and must also address the range of severity of symptoms experienced. A common experience of people presenting at mental health services is to be told that they are not ill enough to be admitted or treated. If what someone needs is a place of refuge or safety until their symptoms abate, and this can take place in a sub-acute setting, then there is an overall benefit to the person concerned and to the whole system.

Case management can be effectively undertaken by those who have experienced the distress of a person with mental illness. Such a person has an intimate understanding of the resources needed to assist the mentally ill person to resume a normal life, and is able to sensitively pitch interventions at the appropriate level.

Because sensitivity to personal needs is of fundamental importance in effective support of people with mental illness, large, bureaucratic organisations are less likely to provide optimum benefit than smaller organisations, which are able to be more flexible. Delivering services through small, non-government services has often in the past been seen as a cheaper alternative. However the rationale for using such services should focus on their effectiveness and flexibility. Funding provided to these services should be adequate to ensure that they can attract and retain skilled and experienced staff.

A worrying and increasing proportion of people caught up in the criminal justice system have mental illness. Although various jurisdictions say that their court systems endeavour to divert such people from correctional facilities, it is still the case that more than half of all prisoners, and in many cases a greater majority of prisoners, have diagnosed mental illnesses. Prison mental health facilities have proved totally inadequate to meet the high demand for their services. Prison authorities claim that people with mental illness in prison receive adequate and appropriate treatment. Ex-prisoners report that this has not been their experience. Consequently, there needs to be a mechanism for scrutiny of prison mental health services which is independent of the correctional system. Prison visitors or inspectors who are employed by correctional systems do not fulfil this function. There also needs to be an independent body monitoring prison mental health services with the authority to mandate change when it is needed.

There is a dearth of residential detoxification and rehabilitation services in many parts of Australia. This lack of service is exacerbated by the unwillingness and inability of alcohol and drug services to deal with people with mental illness (and also the refusal of many mental health services to deal with people who misuse alcohol and other drugs). The integration of mental health and drug and alcohol services is therefore a welcome enhancement of the system. It should be recognised, however, that the circumstances of some people's lives, particularly women's, makes residential facilities difficult or impossible to access. When women are primary carers for children, for instance, if they do not have family or friends who can care for those children during their admission, which can be very lengthy, they risk losing custody of their children in their interaction with the child protection sector. Even if their needs are likely to be accommodated by the child protection agencies they deal with, often their fear about losing custody, or their worry about what is happening while they are away from their families is enough to deter them from seeking treatment.

Participation in the Community and Employment

A focus of recent government approaches to people with long term mental illness has been to remove them from the Disability Support Benefit and return them to the workforce at any cost. This approach ignores the consequences of such non-individualised action. The experience of people who have been dealt with in this way has often been that they end up in short-term, low level employment that does not recognise their underlying capacity, nor their education, training or experience. Their income in such employment is often insufficient for their living expenses combined with their ongoing medical and pharmaceutical expenses, and they end up worse off both

financially and in terms of their illness. Work is recognised as a benefit by people with mental illness, their carers and the general community. However people's reintroduction to the workforce must take account of the relative fragility of the people involved, and must be to work that matches their underlying capacities.

Increasing Workforce Capacity

One aspect of workforce capacity that has not been addressed in any of the COAG plans is the education and training of consumers to equip them to take active roles in the delivery of services to other mental health consumers. While some consumers are already qualified to undertake clinical or other roles, those who are not nevertheless have experience that is potentially of great benefit to their peers. What is needed is a range of educational options whereby consumers can undertake courses pitched at a level that suits their background and experience, and which can be articulated into formal professional qualifications with recognised levels of achievement along the way. This education and training needs to pertain to participating in the mental health workforce, but also to issues of management and governance to enable the development and enhancement of consumer run, consumer managed services.

Consideration should also be given to formalising the contribution made by consumers to the basic professional education of health care workers, both those in mental health specific roles and those in general health service roles.