31 July 2007.

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

Dear Sir,
Mental Health Services in Australia

I am responding to a mental health services matter referred to the Senate Community Affairs Committee on 28 March 2007. I refer to the Select Committee on Mental Health final report of April 2006 titled "A national approach to mental health – from crisis to community" many times though my submission and specifically address some of the numbered recommendations contained in that report.

Background.
I am the father of a young woman who has experienced mental health problems over a period of 10 years and for most of that time my wife and I have been the key support carers for her. In recent years, she has spent a considerable time in acute care, and is now based in supported accommodation with some professional support from government agencies.

Summary
I have particular concerns over the care and treatment of mental health clients who by nature would be classified as "high care" patients. In my view, there are two key areas of concern:

- At a national level, insufficient coordination of care plans between states. For instance there is no mutual recognition of Continuing Treatment Orders.
- At a state level, in Tasmania there is too great a gap between acute hospital care and community-based care. In contrast to the recommendations of many expert organisations, the best community care centre in Tasmania has been fragmented in the past 12 months, resulting in a greater degree of patient problems and re-admission to acute care.

I would welcome the opportunity to give evidence at a hearing, preferably in Hobart.

Following, I list my responses to the Recommendations (R) listed in the Select Committee Report:
R1. Additional funding is certainly needed to achieve a care plan that meets the needs of MHS clients, particularly in a community setting. However, the system must avoid a "one size fits all" approach. For instance, recognition needs to be given in case management of mental illness that co-existing conditions such as diabetes should not be left to another party because lack of attention to the co-existing condition affects mental health as well. Also, it is common for MHS

clients to infringe the law in minor ways and then ignore summonses. Escalation of legal issues can soon be a frightening consequence that disturbs client health to an extent that hospitalisation is needed. An appropriate case management system will nip most of these events in the bud, provided time is allowed in the case management workload.

Community mental health systems that focus primarily on statistical outputs, ordinary office hours and stringent budgeting will fail the people for whom MHS's are established – a relatively small but very vulnerable sector of the community.

Indeed, there is evidence already that where State MHS's reduce their inputs in to supporting their clients, then police, emergency services and acute care hospitals pick up the workload and budget costs.

R2. The rights of people with mental illness to access services in the least restrictive environment should not overlook a Community Treatment Order (CTO). Consistency of living environment and treatment is often important in maintaining independence. Complete freedom usually includes freedom to take part of, or none of prescribed medication. A CTO is in my view preferable to repeated cycles of freedom, decline in health, intervention by the police, and re-admission to hospital.

R6. Harmonising Mental Health Acts would be a good step in improving MHS's overall, in my view. For many years there has been recognition between states of Drivers' licences, Trades' certificates and University qualifications to name but three. Further improvements in mutual recognition of professional standing and Continuing Professional Development can only help service providers and clients.

R10. In Tasmania, a state-wide telephone hotline was established in the past 12 months. The MHS has published some statistics, but the bases of the statistics are weak at best. For instance, how many calls were from clients? How many from GP's seeking information on the new service? How many were school students seeking project information? How many clients were referred to trained officers and received help within 12 hours? In making calls to the Tasmanian helpline, I was told there could be little practical assessment done over the telephone unless the caller and the staffer already have a good relationship. A view that coincided with my family experience. It seems that lesser trained staff and a well–designed checklist would release qualified staff from the hotline to work with Crisis teams that do face-to-face assessments.

R13. In Tasmania, the Tyenna Unit provides an acute care, high security facility about 35kM outside Hobart city, on the outskirts of New Norfolk township. Mental health patients have a number of needs that are not easily met in a city environment. For instance, traffic noise and the energy of surrounding pedestrian movement can stimulate irrational thoughts and actions. From family experience, we see that a quiet, rural surrounding helps MHS clients maintain a relatively stable emotional state where they can gain insight and learn to manage their illnesses.

When clients are settled enough, the property gives freedom to walk for 20 minutes in a large rural area without fear of being scrutinised by strangers, without becoming the centre of unwonted attention, without being tempted by pubs, gaming machines, or preyed on by unscrupulous people.

Progression to a security category when clients are allowed to visit New Norfolk shopping centre is an important objective for most clients and an essential step in any rehabilitation program. New Norfolk shopping centre is a good size for this intermediate step. Not so small that it doesn't have any variety, but small enough for clients to become recognised by sight. A safe stepping stone, too few beds to meet Tasmanian needs, but with potential for expansion.

While the Tasmanian MHS Strategic Plan recognises that more accommodation is needed for "high care" patients, most effort has gone into packages of care for "low care" clients, who can be looked after by Non-Government Organisations (NGO's).

R14. I support the development of discharge plans that are better integrated with Community Care arms of the MHS. In Tasmania, there appears to be insufficient requirements for transfer of patient data from the hospital setting to community care groups or NGO's that take on caring responsibilities after hospital discharge.

R23. (also R35) I understand that Assertive Community Treatment would normally require 16 hours or more, 7 day per week availability of community support teams. In Tasmania, the Hobart-based service of this nature was replaced about 12 months ago by an 8 hour, 5 day service. As a consequence, a number of "high care" MHS clients have had a decline in health and been re-admitted to acute care hospital settings.

R25. Mutual recognition between states and territories of CTOs is long overdue in my view. In 1928, legislation was first passed to recognise the validity of drivers' licences between states. Many other areas have been encompassed since, for instance TAFE and university qualifications, railway gauges, road rules, electricity standards.

The traumas experienced by Cornelia Rau and others mis-identified illustrate to me that a mutual recognition of CTOs needs to be supported by a national register of CTOs with identifying features incorporated. It is important that Australian residents are not mistakenly sent to detention centres or deported, and equally do receive treatment that is appropriate to their illness. A National database of CTOs ought to significantly reduce the risk of misidentification of those with mental illness who have absconded from specified treatment.

R28. One barrier to NGOs delivering good alternative care packages to MHS clients is contractual. Where different services have been delivered in the past by specialist groups within a government department, there were no barriers in transferring information from one group to another in the interests of the client.

I have experienced an unwillingness to communicate between independent service providers contracted to the same government department. In my view, to

obtain effective outsourcing of services to NGOs, contracts should include a provision that ensures feedback communication between service providers in the interests of the client.

R33. As a matter of priority, additional funding for post-graduate training is needed now. Apart from fully-funded positions, one incentive measure might be to offset HECS fees against service in regional or remote areas.

R48. For high risk parents, the baby bonus should be split into fortnightly payments, spread over 12-18months, in my view. Alternatively, the bonus paid into a state-based Public Trustee fund and dispersed according to guidelines that keep in mind the needs of the baby and mother.

R65. That the provision of step-down supported accommodation includes a government service with full professional support between acute hospital care or forensic facilities, and “low care” support offered by NGOs.

R66 and R68. I believe that an integrated community-based MHS centre for treatment of people with dual diagnosis needs to be away from cities and towns. In this situation, we might well consider an equivalent to the aboriginal community concept of moving an offender to an isolated place with a tribal elder in order to come to terms with past behaviour and learn some skills for coping better in future. Mental health patients have a number of needs that are not easily met in a city environment. For instance, traffic noise and the energy of surrounding pedestrian movement can stimulate irrational thoughts and actions. From family experience, we see that a quiet, rural surrounding helps MHS clients maintain a relatively stable emotional state where they can gain insight and learn to manage their illnesses.

R86. One incentive for GPs and mental health professionals to work in remote and rural areas could be an offset of HECS fees against service. For instance, two years HECS per year of service.

Yours sincerely

David Asten
Chartered Professional Engineer.