Submission To Senate Select Committee on Mental Health

By

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Introduction

The Senate Select Committee on Mental Health lists 16 terms of reference. As an individual, I am neither qualified nor experienced to comment on all, so I shall focus on those that relate to particular experiences I have had and issues I have seriously analysed and considered.

Background

I am the father of a young man who committed suicide in 1993 after an 11 day experience with the mental health system, 8 days being in a hospital that discharged him 3 times in most alarming circumstances. He died 28 hours after his third discharge. I have written elsewhere of this experience and attach an article I wrote for The Age newspaper and which was published in March 2004.

Subsequent to the death of my son, my wife, not biologically related to my son who was from a previous marriage, developed a bi-polar disorder and I have faced an ongoing battle attempting to obtain treatment for her from the Mental Health System in Victoria. I therefore have experienced the worst of the Victorian Mental Health System over a 12 year period.

Response to Selected Terms of Reference

a. the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress.

It is widely acknowledged that compared with other illnesses, the care and treatment of Mental Illness is significantly under funded.

In Victoria the Department of Human Services seems to have an endless capacity to churn out strategy papers etc. but fails to commit the resources to give meaningful expression to them.

This is despite the fact that the Mental Health Act states in its objectives:

> **"5. Objectives of the Department**
> The objectives of the Department under this Act are as follows—
> (a) to establish, develop, promote, assist and encourage mental health services which—
> (i) provide standards and conditions of care and treatment for people with a
> mental disorder which are in all possible respects at least equal to those
> provided for people suffering from other forms of illness"

Which part of this does the Department not understand?

How can the Department so openly flout their own legislation by so conspicuously and consistently under resourcing Mental Health Services?

Other objectives under Section 5 are similarly treated in a derisory fashion, including:

> (ii) take into account the age-related, gender-related, religious, cultural, language and other special needs of people with a mental disorder; and
> (iii) ***minimize the adverse effects of mental disorders on the individual and his or her family and community***; and
> (iv) are comprehensive and accessible; and
> (v) are designed to promote the mental health of, and reduce the incidence of mental disorder in, the community; and
> (vi) ***provide for intervention at an early stage of mental disorder***; and
> (vii) support people with a mental disorder in the community and co-ordinate with other community services; and
> (viii) provide information on, and access to, complaint mechanisms about standards of treatment and care; and
> (ix) encourage patients and other people with a mental disorder to participate as far as possible in the development and operation of those services;

Indeed, the Victorian Mental Health Act is rather like the Soviet Constitution under Stalin. The noble words are stripped of any effective meaning.

The operation of the Health System is primarily a State responsibility and suggestions of allocating a larger share of the State Health Budget to Mental Health are frequently countered with the question of which services will be cut to provide the extra Mental Health funding? Of course such a question is impossible to answer while health funding is a zero-sum game and any increase in mental health funding would of necessity mean cuts in other parts of the health system. Thus currently, any increase in mental health funding must come out of growth in the health budget and can therefore only be incremental when a major boost is what is really required.

Increased Federal grants to the States for improved Mental Health services would assist the states to break out of this zero-sum game by allowing a much needed rapid increase in Mental Health spending without any reduction in other health services.

b. the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;

My wife is generally able to cope but experiences occasional ‘crises’ when she requires hospitalisation. Unfortunately, the only certain means of gaining such an admission is by means of serious self harm, such as an overdose or, on one occasion, being struck by a train.

The so called ‘Crisis, Assessment and Treatment’ Teams (CAT Teams) are derisively (and accurately) referred to by consumers as ‘Can’t Attend Today Teams’ or ‘Call Again Tomorrow Teams’, the inspiration being drawn from the standard responses received.

Even when I have called reporting the most alarming behaviour which posed a threat to my wife or, on occasions me, I have been unable to have a CAT Team attend. Indeed, in my area, I believe that after about 7:00pm the CAT Team is one person accessible by a paging service.

The standard advice offered, in response to a request for a CAT Team, is ‘call an ambulance’ or ‘call the police’. Should a patient be unwilling to go with the ambulance, and I do not mean offering physical resistance, the ambulance officers will withdraw with the advice to ‘call the police’.

For the mentally ill, police are the front line of the health system and their ambulances are all too often police divisional vans with no medical supervision.

Contrast this with the quoted response time of 14 minutes for an ambulance in the case of physical illness or injury and treatment by trained Ambulance Officers or Paramedics before and during transport.

Upon arrival at a hospital Accident and Emergency Department in the evening, the rich variety of experiences I have witnessed with my wife have included:

- her being strapped to a trolley and attended by a security guard;
- after my departure, her being allowed to wander off into the night;
- having to wait until after10am the next morning when a CAT Team member arrived to assess her.

From discussions with many other consumers it appears that some areas may be better resourced but the majority have experiences similar to the above.

If any evidence of this is needed, it was provided in the letter Dr Peter Archer, head of the A&E Dept at Maroondah Hospital wrote to the Minister for Health in February 2004. Fortunately, before this letter disappeared into the Departmental shredder, a creative individual faxed a copy to a Melbourne Radio station and the matter became public. I have attached a copy of this letter.

All of this is symptomatic of an under resourced system that cannot cope with demand.

g. the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness;

Efforts to provide information to carers are patchy and dependent on the initiative and willingness of individual clinicians, even when such information is sought by the carer.

In the case of my son, no information was ever provided to those who were expected to care for him after each of his 3 discharges. Family were not even informed that he was to be discharged despite the assumption that they would care for him. He was in effect discharged onto the street.

I now have a much more aggressive approach and will demand, with whatever threats are necessary, information about my wife and how to care for her. This should not be necessary, but all too often is.

Yet another neglected part of the Mental Health Act is S 120A (3) (ca) which states:

> (3) Sub-section (2) does not apply—
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> > (ca) to the giving of information relating to a person who is, or has been, receiving services from a relevant psychiatric service by a member of the medical staff, or a member of a prescribed class of staff, of that psychiatric service to a guardian, family member or primary carer of the person to whom the information relates if—
> >
> > > (i) the information is reasonably required for the on-going care of the person to whom it relates; and
> > >
> > > (ii) the guardian, family member or primary carer will be involved in providing that care;

Section 120A contains the confidentiality provisions and the above clearly and unambiguously exempts the giving of information to family or carers.

Clinicians routinely flout the Mental Health Act by ignoring this provision of the Mental Health Act and denying essential information to carers, often, as in my son's case, with deadly results.

There is no accountability for such professional misconduct which should, when it leads to patient death, be viewed in a similar manner to culpable driving or similar acts. It is simply inexcusable and should not be tolerated.

j. the overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people

There are others better qualified to comment on this from a better knowledge base.

I will simply state that my wife, while in a florid state, exacerbated by alcohol, was apprehended by police while driving. She struggled with one of the police in a manner that constituted assault.

Subsequently, her treating doctor in the public Mental Health system was reluctant in his provision of a statement of her medical condition for the court and the statement eventually forthcoming was minimal.

The Magistrate announced his 'merciful' decision not to gaol my wife, for her actions while in a psychotic state, in such a manner that he apparently thought this was a great humanitarian gesture.

She was however sentenced to a period of community service and received a much greater license suspension than a judge apprehended with a higher blood alcohol reading at around the same time. As in so many matters connected with mental illness, equality before the law means some are clearly more equal than others and criminality is attached to actions that are symptomatic of and a direct consequence of illness.

m. the proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness;

General health services are simply not well geared to admitting Mental Health Patients. The idea of 'mainstreaming' is fundamentally flawed as Accident and Emergency Departments have not been staffed and are not physically equipped to cope with Mental Health Patients in an agitated state who are usually physically sound and mobile.

The approach apparently now being looked at in Victoria is to pretend that the approach is sound and to go ahead and set up a psychiatric admission facility within A&E. This appears to be simply a denial of the flawed nature of the underlying policy and will waste resources better used elsewhere.

None of this is intended as a criticism of the A&E Departments or their staff. These departments are simply inappropriate for disturbed psychiatric patients who are also a source of distress for other patients.

o. the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards

While the DHS in Victoria spews forth its self serving propaganda about improvements in the Mental Health System, the Victorian Auditor General got closer to the truth in his October 2002 report 'Mental health services for people in crisis'. This is available on the internet and should be studied by the committee.

I wrote at the time:

> "It is one of the best reports I have seen and certainly better than the department has been capable of. The statistics are stark. For example, there was 0% of discharge plans meeting all the required standards, only 4% of patient files met audit standards, 0% of Individual Service Plans met all required standards, in only 6% of cases was there evidence of carer collaboration in 'Case Closures', carer psycho-education was absent in 98% of files reviewed.
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> To talk, as the Minister does, about a few more beds here and there, accompanied by extra nurses and dollars is to miss the major point.
>
> What the A-G's report exposes is a massive problem of QUALITY.
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> The problem seems to me to be a reluctance to define appropriate clinical standards and where such standards are defined, they are simply ignored and not met. There is apparently no follow up audit process to ensure that the few standards defined by the Chief Psychiatrists Office, for example, are complied with.
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> What the A-G's report shows is that we are not just talking about a small minority of cases where there are deficiencies. Deficiencies are the norm.
>
> If a manufacturer produced a product and close to 0% of output met quality standards (including safety standards) there would be uproar and law suits. If our Mental Health system operates at this level of quality it is apparently OK.
>
> Of course the idea of setting and enforcing quality standards will terrify politicians who have for years been able to shirk their responsibilities to properly resource the mental health system. They would see it as implying huge increases in spending. I am sure there would be some increase, but what is not being counted now is the cost of getting things wrong."

Nothing has changed.

My comments about quality standards extend also to clinical standards.

When investigating my son's treatment I sought to compare it with any standards I could locate. I was able to locate very few publicly accessible standards published by the Department of Human Services and resorted to statements made by leading academic psychiatrists in a locally published textbook of psychiatry.

There should be a comprehensive set of standards readily accessible to carers and patients so that they can assess the care given against an objective benchmark.

Such standards should be the reference against which actions of clinicians and services are judged, particularly in such forums as the Coroners court.

Other Matters

There are issues not mentioned in the terms of reference which I feel should also be examined and I offer some brief comments.

Risk Management

There is a quite good Australian Standard for Risk Management (AS 4360) which is generic in nature and adaptable to all industries.

Such standards appear to be all but unknown in the Mental Health field.

Procedures based on AS4360 look at risk in two dimensions, the consequences if an event occurs and the likelihood of the event occurring and, by combining the two factors, arrive at a ranking of the seriousness of all risks.

An event that, although not very likely, has severe consequences such as death or serious injury of a patient or freshly discharged patient, will receive a high ranking and MUST be taken seriously and action taken to mitigate the risk.

An event with minor consequences, such as for instance small social embarrassment, even if virtually certain to occur will be ranked low and may be ignored in favour of focussing on serious risks.

The efforts at risk assessment and management that I have seen in the Mental Health System have been simplistic, failed to impose the discipline of examining both likelihood and consequences, and in the end seemed to rely on little more than 'gut feeling' of clinicians. Documentation of risk assessment was minimal or non-existent.

Present efforts are totally inadequate and indefensible when recognised standards exist. Such standards should be used and rigorous procedures based on them developed and applied with proper documentation.

Coronial System

A major function of the Coronial system is to identify systemic problems leading to deaths and recommend corrective action.

In Victoria it has been comparatively rare for Coroners to find fault with the Mental Health System and to make recommendations that could force changes on the system to prevent future tragedies.

There are a number of reasons for this including:

- Lack of expertise on the part of 'Coroners Assistants' who are ordinary members of the Police force attached to the Coroners Court and charged with conducting inquiries on behalf of the Coroner.
- The effective 'outsourcing' of the most significant part of such investigations when the Coroners Assistant gratefully accepts the offer of the solicitors acting for the hospital and doctors to obtain witness statements from staff at the hospital. Those solicitors then control who will give a statement and what will be in it.

- The failure to interview a whole class of witnesses and obtain statements from any of them, that is, fellow patients, who although ill are not stupid and observe a lot of what occurs. They often seem to have a better understanding of other patient's symptoms and behaviours than clinicians.
- The undue reliance on 'independent' expert witnesses who often have undisclosed close professional associations with many of the treating doctors. Instead of this, clinician behaviour should be measured against objective standards of care and treatment.
- The apparent inability of many Coroners to understand complex medico-legal issues.
- An apparent unwillingness to attach blame to any individual which may not be unreasonable, but it extends to finding no fault with systems or the combination of behaviours of a number of clinicians when there were obviously factors placing a patient in jeopardy.

A better functioning coronial system would go a long way to identifying systemic problems and making recommendations to correct them.

Even when a Coroner does make recommendations, there seems to be no publicly visible process where such recommendations are assessed and either acted upon or rejected for clearly stated reasons. This leaves me to create in my mind the images of either a big departmental shredder which disposes of them or a large number of dusty pigeon holes in which they find their final resting place.

What Sanctions Exist When a Government Department Flouts the Law it Administers?

This question is raised in my response to Term of Reference a.

When a Government Department, in this case the Department of Human Services, so blatantly, consistently, conspicuously and continuously flouts the law it administers what can be done? What agency exists to enforce such a law and punish deliberate breaches?

What of the hundreds, perhaps thousands of needless deaths that have resulted over the years?

I call upon the Office of Public Prosecutions to order an investigation into these breaches of the Mental Health Act with a view to prosecuting the present and past Secretaries of the Department and the Heads of the Mental Health Branch.

Attachments

1. Critical Condition, The Age, 17 March 2004
2. Letter by Dr Peter Archer, Maroondah Hospital to Minister for Health