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Dear sir,

I would like to make an individual submission to your inquiry into the Provision of Mental health Services in Australia. I believe that I have a substantial background in this subject having worked as a Consultant Psychiatrist mainly in Sydney for 34 years as well as UK and Queensland. As the community services evolved I was associated with this change and much involved with the forensic mental health services.

However I maintained a private practice up until I went to work in UK. In 1999 I spent a year with a very well functioning Integrated Mental Health Service in charge of an area of Shropshire around the large town of Telford as well as in charge of patients in hospital coming from that area.

In 2000 I held a similar position in Cairns and then became Director of Forensic Mental Health Services in North Queensland based in Townsville. In 2001 and 2002 I was a senior Forensic Psychiatrist at Westmead and Bunya Medium Secure Unit and part time with the Corrections Mental Health Services.

In 2003 and 2004 I was a senior Consultant Psychiatrist with Gold Coast Hospital and Tweed Hospital.

In 2004 because of my extensive clinical and academic experience I was awarded the academic title of Associate Professor at Griffith University, School of Medicine.

Attached is my CV for your information.

I would like to comment on the various issues your terms of reference bring forward in the same order that you have presented them.

I would also like to state that I would be more than willing to take part in any other way such as sub-committees or any other position, in order to assist you in your inquiry. I have taken note of the points 2 through to 13 in your terms of reference.

However, I feel quite pessimistic that anything substantial will come of your report because I have seen little response to the NSW Parliamentary Inquiry only a few years ago. In this much impressive information was presented as to the failing health system and since then it has continued unabated to worsen. However, it is so important that people are aware of this failure, which is so well hidden from them, that I am prepared to once again submit a report. I realise this inquiry may be different being by the Australian Government Senate. If nothing happens again I am afraid the situation will slip further toward a third world health system or the US system.

TERMS OF REFERENCE FOR INQUIRY INTO
THE PROVISION OF MENTAL HEALTH SERVICES IN AUSTRALIA.

8th March 2005

(1) That a select committee, to be known as the Select Committee on Mental
Health, be appointed to inquire into and report by 6 October 2005 on the provision of mental health services in Australia, with particular reference to:

(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;

The National Mental Health Priorities workshop covered many aspects of the progress made in this area in recent times, and the Governor of NSW, an experienced psychiatrist, speech was full of praise. Of course there have been improvements in many regards but will not linger on these.
I would point out the issues that ordinary psychiatrists and mental health workers have found have been discussed at some length over the years and represent the views of many psychiatrists and mental health workers I have had the honour to work with under very stressful circumstances.

The world of mental illness has been soured in many countries by closure of mental health beds. In New York it was at the rate of 1000 per day. The Clinical Director of Mental Health in Shropshire told me when I arrived that there would always be a bed available should the patient present a danger to self or others. I found this to be true. In Queensland in 2001 when I arrived this was usually the case in Cairns but not always in Townsville.

Queensland has had problems implementing the very humane and world leading legislation that makes it virtually an offence to hold a person in the justice or corrections system if they have been found to have a mental illness. Unfortunately they have not funded the psychiatric services for this and as a consequence besides the closure of beds in the wake of the Australia wide call for development of community services in-patient needs have been greatly exceeded.

NSW on the other hand has no such excuses and when I returned to NSW in 2002 I found a worsening bed shortage in Cumberland and Nepean Hospitals. Before I had left NSW I had worked in the prisons service and formed the opinion then that the prisons where de facto psychiatric holding institutions. Prisoners with psychiatric illness were often not been seen at all because they were not recognised by the corrections staff or were refusing treatment. The position was so bad that in any prison yard in NSW one would see animalistic behaviour by psychotic prisoners who were not treated, some because they were unable to be forced into treatment in the prison setting. One such prisoner was described by a colleague to a visiting Professor of Law as being severely psychotic and eating his faeces and

urine. This professor suggested that there are times when the law has to be broken. That is, the prisoner should be unlawfully forced to have treatment. So clearly in NSW the prisons where easing the pressure for a time on the psychiatric hospitals.

However this did not last long due to the reducing beds numbers, the increasing effects of illicit drugs especially Cannabis and other drugs, and the natural increase in population. This push to have inadequate beds came from administrators who followed blindly the national policy to the point where very disturbed patients where unable to find a bed and were held in A&E departments or returned to the community. Registrars and consultants struggled to move patients around in NSW to hospitals, which may have had an empty bed. Phone conversation often degenerated into abuse or lying. The Director of Mental Health suggested the bed state on the inernet but the hospitals simple did not reliable fill in their empty beds because they knew it was a matter of hours before they would be filled again. Patients where shuffled around for example it was not unknown for a patient in Gosford to end up in Bathurst or western Sydney much to the patients and relatives distress. Beds were often deemed to be closed because no staffs were available and the administrators refused to declare to the centre of mental health that the bed was abolished. Much deceit and lying went on.

There were many instances of death or injury that were easily attributed to not being admitted. A patient in Nepean Hospital was placed on leave, while trying to settle over the weekend, and on returning to the hospital unsettled, to his promised beds found it had been filled. He went home and killed himself and others in the family.

The worst aspect of these disasters in national planning was that those who instituted this lack of beds to this extent and carried it out, clearly had the experience and knowledge to predict that deaths would happen and were in my view criminally culpable.

As a result of this chaotic situation in NSW, acute public mental Health staff pressure was enormous and it was a matter of surviving the work place. Mental health has such a poor reputation now that I have been told there are only 200 trainees for 400 places for training in psychiatry.
Many psychiatrists and mental health workers became burnt out or, as I did moved around, or they went into private practice or they retired

completely. There was no effective union for psychiatrists and the nursing unions I have heard were heavily criticised. The public sector unions found it hard to work with doctors because of the doctors and nurses attitude and because of the hopelessness these mental health workers felt

Often in the Sydney and Brisbane regions there are no acute mental health beds on weekends. Patients from Gold Coast get moved to Ipswich or Sunshine coast areas for example.

This mess is constantly worked on by "spin doctors" in hospital administrations and Bevery Raphael, the Director of NSW mental health, is well aware of the deaths that have occurred and I have been in a meeting with her she was told of the deaths in a de-facto psychiatric unit in Kempsey a few years ago.

The NSW Parliamentary Inquiry has documented the situation but little seems to have been done until recently when media attention especially by the Sydney Morning Herald has been causing some discomfort to those responsible.

The only time I have seen a real response to psychiatrists anguish was in Cumberland Hospital in 2002 when there was a very real threat of a strike by the psychiatrists which leaked to the media, and we had 6 more beds within a week or so.

I would suggest that NSW at least has not even come near to achieving the national mental health initiatives and in fact the situation has worsened with community workers having impossible clinical loads and not able to achieve the supervision of difficult cases that they should be getting.

I have seen this system work well in UK but one has to recognise that looking after a patients in the community is just as expensive as in hospital or even more, especially if the supervision is inadequate. In assessing the damage done by the zealous application of the National Mental Health Strategy one has to take in the recurrence rate, the damage to the community in terms of death and destruction etc
The Bureaucracy in the NSW state mental health is so large, ingrained, ignorant and unresponsive to front line workers that I believe that the only answer is a take over by the commonwealth. For example in the top 4 levels of this bureaucracy contains no doctors apart from Prof Raphael.

I was often told “one has to work with what you have” and on one occasion when I was acting Clinical Director of Mental Health in Nepean Hospital I was told “you have beds on the brain”. There was little support and nor did most mental health workers have faith that the true position in the hospital or community services was being accurately reported. There was little support generally and much unhappiness “in the ranks” about the danger to patients and staff in terms of physical and legal danger. This situation continues unchanged in hospitals that I know of in Queensland and NSW. The other ‘come back’ that I heard from bureaucrats high up and low down the ladder was that “if we provide beds you will fill them up”. That is the way it must seem from behind a desk but when faced with a desperate potentially dangerous patient, and equally desperate relatives and friends who are unable to afford private treatment, it is very different. We are the ones who have to make the excuses and dubious arrangements for these unfortunate Australians, and, shoulder the consequences for the abysmal mental health services with an inquiry into the slightest action, which has threatened the safety or may produce legal actions against the hospital or staff.

(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;

Surviving the above dreadful conditions leaves little reserve for mental health workers to think of more than the fast acute care and discharge to the overworked community staff. It is true that most hospitals have managed to involve community staff in their discharge planning which was a routine in UK. I am sorry to say that UK is at least 10 to 15 years ahead of many Australian integrated mental health units. Treatment with medication and the briefest of behaviour treatment in the acute setting is all one can mange and in the community the same applies. Many hospitals have psychotherapy facilities run by psychologists but they are usually booked months ahead. I must say this also applied to UK community services to a varying degree when I worked there in 1999, especially in the cities

There has been an emphasis in child mental Health units toward prevention and this is most heartening as there is good evidence of the effectiveness of

prevention of mental illness and reduction of crime by Sheilagh Hodgins, Professor of Psychiatry in Maudsley Hospital, amongst others.

After-hours crisis care is a feature of many integrated Mental Health Services NSW and Queensland and this has been a most effective way of preventing admissions and readmissions. Once again the lack of beds serious interferes with this service.

Some hospitals have introduced a supportive service to their local A&E department but the application of this is patchy. It is often part of Acute Care and Assessment Team ACAT, but I think this support should be separate and called something like “Emergency Psychiatric Service” (I was involved in the development of such a service in the Gold Coast Hospital), leaving the ACAT team to follow up and take phone calls etc as in Gold Coast Hospital.

Often patients are admitted who are desperate or their relatives are desperate but I have never seen or heard of respite centres. Usually if the patient is held too long, some bureaucrat turns up asking questions about the patient’s need for continuing admission. There are such centres run by NGOs and these are helpful enough for a few patients. One such organisation even attends rounds at Tweed Hospital.

(c) opportunities for improving co-ordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;

I think there is a huge need to co-ordinate and ensure appropriate care but people not in an active hospital clinical role should not do it. Generally in UK the team treating the patient in the hospital and in the community has a secretary. This team consists of the community team, nursing staff on ward, registrar and consultant in charge of the area, which is around 40 to 60 thousand people. There is no need for anything further. In Australia everyone fights to get office assistance and usually registrars and consultants are lucky to even have an office (see Hornsby Hospital). It is essential that the main treatment provider, usually the GP be kept up to scratch with hospital and community treatment.
However the main thrust of this question is better answered by the following, which refers to reports that should be included in your brief of documents and is as follows;

SMH 19/3/05

Threat of sick-hospital syndrome spreads

By Ruth Pollard, Health Reporter
March 19, 2005

Inadequate early warning systems and a dysfunctional work environment mean that it is only a matter of time before a Campbelltown-Camden-like crisis cripples other hospitals, experts predict.

Despite several attempts at restructuring the NSW health system - most recently by reducing the number of area health services from 17 to eight - the Government was no closer to resolving the problem, said Jeffrey Braithwaite of the University of NSW Centre for Clinical Governance Research in Health.

"Change in hospitals will require deep-seated adjustments to the enduring subcultures, work practices and webs of relationships within clinical wards, units and departments," Associate Professor Braithwaite says in a study published in the Journal of Health Service Research and Policy.

Restructuring alone was just "wasted energy", he said.

"Doctors and nurses often ... look up at this big organisational restructure that happens six or eight layers above them ... and they keep on doing their work regardless. It seems to leave relatively unscathed the way clinicians do their work."

One problem is that doctors, nurses and allied health professionals were trained separately, then expected to work in multidisciplinary teams on the hospital floor, he said.

"It should not be any surprise that clinical pecking order remains. Quality and safety suffers in an organisation that is culturally poorly performing, as does efficiency, so there is a cost implication as well."

Is every hospital a Campbelltown or Camden waiting to happen - where poor structures, inadequate resources and overworked staff led to substandard patient care?

"Unnervingly, I think that is possible - although in one sense we can never really avoid that, because every complex human system will produce errors," he said.

Only strong leadership will overcome the problems of the NSW public system, said Arthur Richardson, the chairman of the state committee of the Australasian College of Surgeons. "It requires a whole sea change in the workplace culture of hospitals," he told the Herald. "In the public hospital system you are not rewarded for doing more and better work, instead the administrators are just looking at the bottom line."

Describing the system as "monstrous, with an enormous budget and all sorts of entrenched empire building", Mr Richardson said its organisation did not allow for efficiency gains. "Most people have just about given up on the public hospital system," he said.

In a second paper, published in the Journal of Social Science and Medicine, Associate Professor Braithwaite and colleagues studied two metropolitan teaching hospitals, one in Sydney and the other in another eastern state.

The differences were stark, he said. One had a more productive workplace culture, where the staff worked well together in multi-disciplinary teams. In this hospital, staff felt they had good leadership, better structures and were optimistic about being able to meet their future work demands.

The other hospital cited poor working relationships, uncertainty about the future and less patient focus, mainly due to bad leadership.

Associate Professor Braithwaite warns that patient safety is most at risk in badly run hospitals.

I have found that the contents of this report to accurately reflect the current past and present situtaion.

I would also warn what I assume you already know that looking at out comes figures can be missleading. Look at figure such as the readmission rate and the occupancy rates to get some idea of how they are functioning. The staff permanancy rates also give an

indication of how well it is functioning: staff do not like leaving a well run unit.

Recommendation: Complete "sea change" and Commonwealth review of the enormous beurocracy when it takes over the mental health services.

(d) the appropriate role of the private and non-government sectors;

Ever since I left the initial position I had at Macquarie Hospital as Deputy Medical Superintendent, I have thought what a waste it is not to heavily involve the private sector in the care of patients. The very least would be discharge letters to GP and this is generally done except that the Discharge Form is often of little help as there is not real advice and offer of help in follow-up due to the pressure that all mental health personnel work under. There should be an integration of private and public hospital at the very least in terms of training of registrars. In one hospital the treatment and discharge of patients was considered "Core work" and all the rest such as training of registrars and nurses was considered "non-core work" and discouraged. I was heavily criticised when I established (in the lunch break) what the visiting college inspecting committee, considered the best training regime in the state.

Research would be another area that private and public hospitals could co-operate but the public hospital staffs simply do not have the time or encouragement to be involved. In UK there was one day set aside for research and training and perhaps reviewing urgent patients.

I am sure that some private hospitals could specialise in certain treatments that should be supported by the public sector such as Anorexia, cognitive behaviour therapy etc.

Private psychiatrists are not even notified of the academic activity in a hospital unless they are on the staff. When in private practice I did approach the local psychiatric in patient unit and they were most surprised and I attended on a regular basis.

(e) the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;

The lack of supported accommodation is one of the greatest disgraces in the Australian mental health scene. It means that carers are alone virtually, apart from the lucky areas where there are some dedicated community mental health services. I can't emphasise enough the desperation and hopelessness that these carers feel as a person who is mentally ill demands their total attention day in and day out. The NGOs can only do so much but the scene is anti-therapeutic to say the least and at the other extreme dangerous with many carers being killed in the psychotic delusional atmosphere of the home, especially mothers. I also warn Carers in these situations to get out of the house if they feel in danger.

The best psychiatric rehabilitation I have ever seen was when I worked for two years in the Buya Medium Secure Unit, in Cumberland Hospital Grounds, Parramatta, where most of the patients had killed someone and been found not guilty by reasons of mental illness. Over 1/3 had killed a relative. The rehabilitation was supervised from a legal point of view by the MHRT and it was really too slow with any substantial changes in leave having to go to the MHRT, the NSW minister for health and then the Governor of NSW. However despite these often, unhelpful intrusions to the careful management, patient moved gradually to be released, if they coped with the steps, ending with a Villa in the grounds for many months or years at least. Finally after years they were found supervised accommodation usually with great difficulty handled to the normal Community services. Of course they should be overseen by a forensic mental health service such as I set up in Townsville but, of course NSW does not still have one. Unfortunately there are only 25 patients in Bunya unit whereas in UK these units run into the hundreds. NSW has only two with the one at Morisset being more chronic than the acute patiens in Bunya. There is constant political interference from different levels. Part of the problem is the lack of any acute care for women in the corrections service for many years. This gradual unhurried rehabilitation for many patients was the norm when there were the old "Bins" for people to find asylum. Now they are often cast into society to largely fend from them selves with inadequate services. It is very inhumane and third world.

Any psychiatrist or psychiatric nurse could have, and did, warn that this would happen and that the people cast out of intuitions would largely die after a short time. This is what the National Mental Health Strategy meant to very many patients and I believe it was with intent and knowledge and

so was a criminal act and continues to be criminal.

(f) the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;

Nepean Hospital had no elderly services in 2002 and both teenagers as young as 15 and elderly as old as 80 were in the same inadequate ward with violent drug offenders. There is little account of special groups in many so called integrated mental Health services in Australia and the rural services struggle on in typical many uncomplaining manner of country people. For 10 years I did second monthly trips to Young in NSW and was the only psychiatrist at that time visiting there. I was there in a private capacity and worked mainly by bulk billing. There was one nurse for the town at that time including after the National Mental Health Strategy had been implemented!

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

The only help I have ever seen for Primary carers comes from some supervision by mental health nurses if they ask for it or if it is suggested by psychiatrist etc.
Only yesterday in my small private practice I saw a father and son. The son is being followed up by a psychiatrists and caseworker. The father described to me how he has to go to the community centre and “ have a fit” to get any real attention for his son. In my letter to them I suggested that the father needs regular session about once a month to get support. This will be considered a novel and perhaps unnecessary process I suspect. The son is actively psychotic and treatment resistant. There is NO respite or support for the father. He was lucky to find a bulk-billing (for pensioners) psychiatrist. It is little wonder many families consider murder suicide. All this with the new the National Mental Health Strategy.

(h) the role of primary health care in promotion, prevention, early detection and chronic care management;

Quite clearly the GP is the lynch pin in this role but who would want to be a GP? I don’t know how they function with little support unless they

actively seek it out from busy mental health workers. These nurses and allied professionals really are not placed in a position where they can support the GP as the system is denuded of psychiatrists who go into private practice at first opportunity.

This situation is even worse in the rural areas and for indigenous peoples. One of the reasons I liked to visit Young was that the GPs were so eager to find out what I thought.

I think the National Mental Health Strategy disgustingly over looks GPs. They are underpaid and overworked and have to be dedicated to medicine to survive. The current government is merely scratching the surface in supporting them.

Recommendation: to improve the working relationships with GPs and the mental health Hospital units and community mental health services. Perhaps involve them in a working sessional relationship in which they are adequately paid.

(i) opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated;

This is so much pie in the sky it is insulting. These are the sorts of sounds bureaucrats make. How on earth can one deal with this nonsense when one is dealing with such chaotic and pressured services that will not even recognise “non-core” issues. What is proposed is exactly what is happening now if there were adequate staff. Carer groups are involved and the aim of all community staff IS recovery-focused care with the involvement of the carers. I think the person who wrote this should be sent out to work for 6 months with a community mental health team. Of Course it is important to have carers involved in some meetings etc but really in the turmoil of the acute units they would be scandalised.

(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;

I have been working in medico-legal work for 30 years in civil and criminal jurisdictions and Mental Health Law as a member of the MHRT for 10 years and two years in Medium Secure Unit called "Bunya" at Westmead Hospital. (see attachment 8.8.02)

In 2001 I was director of Forensic Psychiatry in North Queensland and trained specifically for Forensic Psychiatry doing a course at the Institute of Psychiatry in Forensic Psychiatry, then a year with the law students at Macquarie University, passing in Criminal Law and Procedure, and in the two years following this I completed a Masters in Criminology at Distinction level at Sydney University Law School. Thus I believe I am especially qualified to speak on this topic.

Without doubt there should be a national mental health act and the best in Australia is in Queensland BUT it is under funded there. This act is especially excellent and follows the requirement of U.N. World Health requirements.

In Tweed and Gold Coast ridiculous situations often arise, for example, with community treatment orders made in Tweed is useless less than 4 kms away.

There was a survey at Long Bay Prison by a Professor of Forensic Psychiatry who found that male prisoners with mental illness were around the 60% rate and 25% for Psychosis. Women prisoners for psychosis were close to 50-60 %. These findings have been repeatedly found in Australia except Queensland where is virtually illegal for any person to be held in correction or by the police if they have a mental illness and they have to be held in a psychiatric unit. If there is a major problem they may be held in a Forensic Mental Health Unit. They have a special mental health Court to handle these patients in an inquisitorial system.

It seems rhetorical to tell the informed people reading this report that prison is ant-therapeutic but it certainly is. Often in NSW prisoners have not been able to be treated because they refused treatment and only a few years ago one could see animalistic behaviour in the prison yards coming from psychotic prisoners. The NSW Government will tell you of all the improvements, which are 30-35 years behind UK and other civilised countries. In 1970 the first medium secure units were developed in UK. I

was shown over one in 1971 with Prof Bluglass, who was the director, and Dr Martin Donavan who was a junior doctor with me and became a Forensic Psychiatrist. I would also add that my estimate, which, I have checked with other psychiatrists who have worked in UK, is that our Mental Health Services are about 20 years behind the UK in general. I would be happy to enlarge further with you about this subject in particular if you wish. I would be most careful about obtaining information from state employees because they are treated as whistle blowers after as I have been. Victoria is more advanced than NSW or Queensland but I do not know about other states. The comment from forensic psychiatrists about NSW is that NSW has correctional mental health services and this has been shown in UK not to work.

Recommendation: The Forensic Mental Health Services need to be reviewed and states brought into line, along with the mental health law.

(*k) the practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimizing treatment refusal and coercion;*

I have almost never seen anyone in held in the public sector held for excess times or seriously mistreated but I certainly can refer you to the Chelmsford Royal Commission and the Greek Conspiracy case to see psychiatry at it worst. Detention is essential for those who are reviewed by the Mental Health Review Tribunals and in fact I believe that holding a patients for 6 weeks before the review is conducted is reasonable because it is a very disturbing experience for many patients to have their “case” aired in the tribunal. Any Australian psychiatrist in a public hospital will be most unlikely to hold patients unnecessarily. The exception that I have in this regard is a patient held in an acute mental health facility at Tweed heads Hospital who has been there for nearly 500 days when he should be in a chronic rehabilitation ward and not continually disturbed and set back by other acute patient. He has had to have periods in seclusion.

Seclusion is a sign of inadequate staffing or architecture on the unit and perhaps management. Most patients can be sedated and nursed one to one or “specialled”. There has to be very tight monitoring of such patients in seclusion and most hospitals that I have worked in has such controls. There

can no more demoralising and confusing action than to seclude people and it will worsen their mental state.
Competent, well-staffed and well-trained staff do not need to seclude except very occasionally for their own protection. Seclusions were hardly ever used in the Shrewsbury Hospital I worked in or Bunya Medium Secure Unit, Cumberland Hospital. Detention is however essential to treat psychotic illness and severe Personality Disorder.

Recommendation: To adopt the Queensland Mental Health Act and adequately fund the change and move to the Forensic Mental Health staff with suitable hospitals and the plentiful use of rehabilitation medium secure units. These units have been proven repeatedly by UK governments over the years to be economic preventative crime methods as well as realistic treatments units.

It is however vital that the day-to-day running and gate keeping stays firmly in the hands of the forensic psychiatrist director and not into the hands of judges, corrections or politicians in any manner or form. Forensic Mental Health Community Services are fully developed for continued preventative crime and mental illness tools. The Legal aspects placed in the hands of The Mental Health Court presided over by a Supreme Court Judge as in Queensland.

The cost shift from Attorneys Generals of the various states and from the Corrections Departments must be assured.

(l) the adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers;

How can one concentrate on education about mental illness when we are treating those with mental illness as third class citizens in such abysmal conditions of inadequate buildings and staffing both in the community and hospital. What must carers think?

Recommendation: I hope you canvass this question to the Carers groups such as "the Tweed valley Mental health Carers Network"(Phone, 07-5506 7336. E-mail: junesaville@ozemail.com.au)

Carers are shocked at the conditions that we work in and the way we are treated by the Bureaucracy.

(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;

I agree that these departments have little idea of how to cope with the mentally ill. They get little guidance from the mental health services and rely on over taxed social workers and other staff.
Recommendation: Develop a Mental health Ombudsman who can relate to such departments in a case-by-case fashion and who can develop agreements with them on handling the issues that arise.

(n) the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated;

The matter of research has been mentioned but clearly both quantitative and qualitative research has been actively discouraged as a "non-core business" in the public mental health services. Many of my colleagues have struggled and negotiated to be able to do some research, usually in their lunch breaks. The Australian College of Psychiatrists have not been at all supportive and should have been stipulating that such activity is not "non-core" and an integral part of a professional continuing development. In the UK it is a condition of recognition of the hospital or community service that such activity is encouraged. An example of the college apathy is that in UK it is compulsory for registrars to have their own office where they can work and study. This is not the case in Australia. Even consultants are lucky to get an office unlike managers.
Best Practice is a obviously a good idea but again is looked on as a non-core business in NSW and some Queensland hospitals. With Continuing Medial Education compulsory it is rather unnecessary and I believe we have always aimed to achieve this. What is missing is that we do not have the time or encouragement to educate nurses or allied professions. Many psychiatrists are encouraged to work part time and do not have the commitment to the hospital needed to achieve "best practice" knowledge in other staff.

Recommendation: That all staff are given the time and encouragement to participate in continuing education and teaching and research is seen as part of their remit. Best Practice will follow this healthy academic atmosphere.

(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; and*

There has been a considerable push in NSW for data collection at the expensive of clinical standards often. Clinical staff are spending many hours filling out the forms instead of dealing with patients and spending time in simplistic lectures about how to fill in the forms. Most doctors ignore the forms or only fill out the bits that are of clinical significance. Unfortunately the nursing staff have to fill in the missing bits and there has been some conflict over this. Whether it is adequate or not is unsure as we hear little of the result. I suspect the information may be too embarrassing to release easily or embellished?

Recomendatioin; Bring the staffing levels and patients beds to a civilised level and this data information will be of some interesting significance.

(p) *the potential for new modes of delivery of mental health care, including e-technology.*

The Labour minister in the Whitlam government commented to a psychiatrist as he was cleaning out his office that they all knew that the most efficient form of health care delivery was in the private sector.
I agree with this but think we should be keeping an eye on the developments overseas including the Scandinavian countries.
I think e-technology can be useful in a number of areas. I have the habit in private practice of taking notes on a lap top as the patient talks and then sending these formatted notes as a letter to the GP immediately after the patient leaves by mail, fax or e-mail. I have kept all my notes in electronic form. I think the use of electronic note keeping and test results, can make feed back to referring agencies extremely easy and fast. I believe that something along these lines is used at the Private hospital near Westmead hospital in Sydney.

The privacy issues of electronic notes and test results need to be considered in the public sector.
Clearly the use of computers in hospitals in Australia is well established.
I have also participated in Mental Health Review Tribunals using the Internet for interviews and this is quiet well established in NSW. Patients do get a little confused at times but as the population becomes more sophisticated, this problem should ease.
It would help to have an Australia wide medical and psychiatric record if it was secure.
Within a short time PET scanning etc will be used to support psychiatric diagnosis. It would be a good idea to prepare for this by watching closely what is being developed overseas instead of Australia persistently lagging 10 to 20 years behind.

End Statement

I am deeply sorry that my speciality has sunk to this low in its development in Australia. Why do we have to be so slow to realise the harm that has been done to our fellow Australians?

Why, for example, has it taken us so long to recognise the horrific dangers of Cannabis with the British Journal of Psychiatry in May predicting the incidence of Schizophrenia going from 1% to 7 % soon because of Cannabis? I have been saying this for 20 years to a thick brick wall.
Is it really as the British often tell us that we have lack of intellectual ability and subtle? We certainly have in the past (WWII see Politics of War by David day) but why can't we listen to our own experts?
Others and I strongly feel that the states have failed and continue to fail in their delivery of Mental health Services despite repeated warnings. We need to try again with commonwealth taking over health and especially mental health. By this means slashing the many layers of financially absorbing bureaucracy.

I repeat that I will be willing to spend any amount of time to assist you in any capacity in your endeavours.

Your sincerely

Associate Professor Brian Boettcher

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