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Ian Holland
Secretary Senate Committee-Mental Health
Parliament House
Canberra ACT 2600

[redacted] 16/6/05

R[redacted] Died age 27 within days after being discharged from Monash psych ward, Clayton.

Dear Committee members,
I am writing to try to raise awareness of the plight of the mentally ill, those with severe head injuries and those with drug & alcohol related illnesses and the impact that lack of funding is having on them, their carers and immediate community

I have already sent a slide show of my son's life to you on a CD disk.
I would like to present and discuss it with your committee It covers a span of some 30 years of experiences with the mental health issues and the lack of support for those issues.

It also puts faces to the statistics.
It shows:

- The complexity of the issues
- The secondary impacts of not having suitable beds or counseling services available for the initial patient's problem (serious head injury), creating a domino effect.
- The impacts of privacy legislation on the ability of carers or family to locate those who are missing or help to manage their affairs.
- The importance of children's reports being an accurate reflection of their current performance. (As a teacher I have been told you cannot mark a child back, it will cause all sorts of problems with "cases". There is also subtle pressure to up mark) the child's report may be the first and only indication that the child is experiencing difficulties. If this is camouflaged, an opportunity for early intervention may be lost. I missed this indicator with my son because of the impacts of my brother in law's head injury on my husband's health.
- The lack of early intervention. The victim is often blamed. (My son was asked to leave the Grammar School he was attending...because he was not functioning...we were told we were wasting our money. No effort was made to support my son through a difficult situation.
- The difficulty in accessing mental health services.

- No accommodation available that was suitable for complex needs caused by head injuries /physical difficulties/behavioral problems. We had looked for suitable supported accommodation and could find nothing. My notebook was full of places that said "no". The local MP in Mentone at the time, tried too. He agreed, there was nothing. He helped a worker for Yooralla to get funding to start up Headway. We found one suitable place, the hostel on the grounds of Caulfield hospital, but it also said "no". Our local member of parliament suggested we take him there, with his bags packed, and leave him with them, just walk away. That was so hard to do. But it was the only way we got him into a suitable supported accommodation.
- Years later this was closed and it began all over again. He was placed in nursing homes. Female staff on duty at night began phoning my husband at night to come to help them manage his brother because his behavior was unmanageable. My husband went, but I phoned and asked them not to ask him again because he'd already lost his health, his business and his home once trying to help. I told them my husband's health is worth something too. When his health was affected, so was my son's and daughter's as well as my own. My husband's sister's health had also crashed to the extent that she had to leave her job. (30 years after his accident, he has only recently been placed in a community supported accommodation house with others of his own age.)
- The difficulties faced by those with an unstable address of accessing a CAT team.
- The unforeseen consequences of intervention orders in relation to contacting a CAT team. (They will only attend with police present. But, with police present, the client goes into hiding.)
- The difficulty of staying/getting connected to a caring community.
- The lack of communication by psych ward staff with carers. The tendency to treat an acquaintance who simply visits as the carer because they are more visible. Family often work and are therefore less visible.
- False statements in documents used in my son's first mental health review.
- Harassment for bringing this to notice. (We thought it was going to be a counseling session. It turned into harassment. My son stormed off. I stated that if my clients don't understand I expect them to ask. It seems that medication is the main focus, not counseling.
- Staff ignored the family background knowledge of the individual.
- The failure to follow through in organizing meetings that the family had been advised would occur before discharge.
- No meeting prior to discharge to give time to discuss or arrange supported accommodation options. (Three had been found by family, my son had expressed to me he'd like to go back to the one of these that he had had good experiences with. He had developed trust in those running the program when he went to their 12 steps program for 5-6 months prior to his illness. He had made new friends there.)
- Not informing the client's drug & alcohol treating GP that he was going to be or had been discharged. (My son was discharged on 5/3/2003, his drug & alcohol

doctor/GP received discharge information on the 14/3/03 at 19.53 hours, after I had notified police he was a missing person.

- Not informing the client's drug & alcohol treating GP or family, that medication that was prescribed to protect the client had been stopped (I only found out on the 8/3/03, when my son came and told me he was in withdrawal and wanted to get back onto Bupromorfin.)
- Discharging prior to long weekends or holidays. My son was discharged in the week prior to a holiday. He just managed to catch his drug and Alcohol GP, before he left for his holiday break. He waited for my son.
- Discharging the client with no prescription for the medication that was prescribed by his GP to protect that client from depression and a drug dependency. (I had prepaid the chemist in case my son was discharged unexpectedly. It is beyond belief that he was not given a script for his Bupromorfin on discharge.)
- Drug dealing on the wards. Vulnerable people are at the mercy of dealers. No attempt appears to be made to check or keep a record of visitors. (Even schools keep a record of visitors.) My daughter overheard two nurses talking about a dealer on the wards. Was any action taken or was it considered "normal"?
- My son died because of a disastrous discharge procedure.
    - No meeting to discuss accommodation and to arrange it before discharge, (as we were informed would happen at an earlier meeting).
    - No discharge information to the patient's GP before or on the day of discharge. (Only well after he was notified to police as missing and probably dead)
    - No urine test to establish his status as an addict. (When they had phoned to say they were discharging him, I had phoned back and asked them to at least do a urine test. I was told on the phone that they would do this. When I phoned back, they said it wasn't done.)(My daughter later told me the staff had told her he no longer had a drug problem!)
    - No notification to his family or his drug and alcohol treating GP that he had been taken off buprmorphin that had been prescribed by his GP, nor that he had been using while in the psych ward.

This is just one family's story.
This is repeated far too often.
Let's fund prevention, early intervention, beds and appropriate supported accommodation on discharge with counseling.