Sent: Monday, 25 April 2005 12:32 AM

To: Committee, Mental Health (SEN)

Subject: Mental Health/Senate Committee.

Submission to Senate Select Committee on Mental Health, Parliament of Australia. 2005.04.24

* In terms of in-patient beds we are struggling.
You don't have to fill beds, but if you don't have them you can't!

In particular, this is largely because of the grossly inadequate attention to extramural needs in our community (not just mental health service resources).

If these were adequately attended to, by all sectors (departmental/voluntary/private), we could do with less in patient beds than otherwise, but looking at the potential growth of communities and the high likelihood that Treasuries are unlikely to allocate the necessary funds, that prospect is remote.
There will always be a need for some involuntary admissions. These must be provided as close as possible to the subject person's domicile.

* However, the major proportionate task is to meet the extramural needs.
The in-patient unit being seen within the context of the whole service, rather than the other way around (as is so often the case, in part because of its salience, the self interest of many professionals and because of a general lack of perspective in this area).

* It is vital that maximum use is made of our great fortune in having such well trained doctors so widely available, by world standards.
It must be a given that each person has their own local general practitioner doctor of choice.
The local GP is the specialist 'conductor of the health care orchestra' and undertakes the 'womb to tomb' primary care which underpins all other specialised health care.
At all points the specialised mental health service must work with the local GP, in any particular 'case', not in special negotiated 'shared care' arrangements, but in fulfillment of mutually respected roles which are inherent.

* It needs to be understood by all, that 'special pleading' must be heard (and respected in planning) from minority and marginalised groups - the handicapped, prisoners, various racial groups, emotionally disordered and so on.
Without that there can be no reform and there is likely to be massive cost in human, mental health and money terms.
More importantly, if the more progressive administrators are to retain credibility, they must justify their rejection/modification of those aspects of the collective feedback that they say they are so keen to have.

I have long advocated that in all planning there should be an attempt at a 'mental health impact statement', as with environmental concerns.

* It is also crucial to be aware that the N.S.W. Mental Health Act is currently under very active review.

* It is my own long held view that we should not be building more 'pods'/units/wards/ in general hospitals for 24 hour/7 day a week care of people with mental disorders. I believe they are a throwback to planning ideas in the early 20th century.

Advocacy for them was partly motivated by the frustration with reform of the 'bins' (large mental hospitals) and the need to 'mainstream' psychiatry as a medical specialty.
In the later part of that century the thrust became stronger when the Australian government was willing to fund general hospital developments but saw 'Schedule 5' mental hospitals as the responsibility of the states. The states jumped at the opportunity to get federal funds of course and more general hospital psychiatric units followed.

Along came the 'Community Health Program' designed to boost extramural services with the hope of integration of inside and outside and comprehensive planning, but the funds dried up, some funds were filched to the institutions and the hospitals were left lamenting and envious. So it became 'them and us' - inside and outside.

* It is my view that general hospital architecture and functioning does not lend itself to mental health care. Nor does the recent design of mental health units in general hospitals give me any hope or joy.

I consider the place(s) of round the clock mental health care should be readily accessible by walking, to and from the relevant general hospital, and sharing its resources for all sorts of medical reasons and economies.
It needs to provide a 'homey' environment, with that look and feel, in which people are up and about in street clothes, preferably to have its own street address, while having provision for some secure area and ready observation where needed.

* Because it is staffed round the clock, it is economic to provide communication and coordination of the mental health service from its staffing.
Allied with that, other staff would need to be available (out of hours on-call, from their homes andor staff resources of the general hospital), to either undertake domiciliary and other extramural activities or replace on duty staff for that purpose.

In this way there would be less need for staff to be kept on site, in 'idle time' and greater attention could be given to continuity of staff personnel in care (e.g. someone who was known to a former ward patient could be engaged in a domiciliary visit to that person's home, or called in consultation to the A & E Department of the hospital).

* There would also be the prospect of 'day hospital' activities linked with in-patient activities on site, with a greater willingness of people to approach the less stigmatising setting.

* I re-iterate one of my long standing suggestions, for all mental health services, that greater use needs to be made of indigenous resources for accommodation and treatment/rehabilitation.

There are local talented and generous people rattling round in 'empty coups' and others with families, who would be willing, with support, training and appropriate remuneration, to house people with emotional disorders in their own homes.
Sufferers could be treated in such settings, as an alternative to hospitalisation.
Others could have longer term placements, with a view to gaining the skills for independent living.
There are models of such arrangements around the world which have demonstrated the effectiveness of these strategies.
This simply requires the will, the understanding, the budget, the leadership and the necessary cooperation of all concerned.

* A similar conceptual framework applies to employment.

* This is an excellent opportunity to assert the need for comprehensive and integrated planning of mental health services, with generous Australian government funding requiring this and providing flexibility, so that money can be made available for innovative programs for alternative care involving all sectors (departmental/voluntary/private).

In particular the voluntary sector requires vigorous support.
It is from that sector, historically, that most effective reform has taken place in mental health services and care.

* A major on going problem in our prisons is the lack of adequate health services, including mental health services, to say nothing of the perennial problem that prisons are generally more likely to be places *for* punishment, rather than for deprivation of liberty as *the* punishment.

Apart from the hard core minority of prisoners who require special levels of security, I believe that many of these inherent problems could be largely overcome by housing the majority of prisoners within their own communities of domicile.
There could be medium secure 'homey' provision of housing, staffed by prison officers also living in the locality.

The prisoners would have more ready access to their usual local services - medical/mental health, dental, legal, occupational, educational and so on - bringing the prison to the resources, rather than trying to provide them (again) within the prison itself.

The prisoners and their families would have more ready access to each other and they would be in a less anonymous situation, so that their progress in rehabilitation could be more apparent to all.
This would also tend to lessen the tensions resulting from deprivation of liberty and the alienation so often resulting within families as a result of forced incarceration at great distance.

The local communities would be more aware of the humanity of the people involved, rather than them being 'out of sight out of mind', and 'other', to be rejected on release.

Such a proposal was put forward, by me, decades ago, in the Central Coast of N.S.W. and had general agreement from all relevant local departmental operatives.
The relevant numbers of current prisoners was established and the probation and parole officers were enthusiastic enough to identify the necessary housing.
Several prison officers living locally also offered their services and their union supported the proposal.
So it gained practical momentum.
It was not implemented for lack of political will at the highest level.

Again, analogies can be drawn with enlightened mental health provisions which are located in proximity to the domicile.

Probation and parole services and the courts are also learning the value of such strategies as work release programs as potential alternatives to imprisonment.
Many other strategies are becoming available with developing technologies e.g. monitoring and controlling movement of subjects outside prison.

[I was influenced in all this by my experience of the valuable reforms and modifications taking place in the provision of more rational mental health service in Australia and around the world.

The N.S.W Director of Correctional Services had learned and declared that the number one complaint of prisoners in N.S.W. was the lack of effective health services for their care.

In addition, the retired Ombudsman of New Zealand, at the same time, declared his belief that 'the number one problem in mental health in New Zealand is its prisons'.

Already Dr Charles Noller had done a study on long term rehabilitation programs for problem drinkers.
He found that in (usually distant) residential programs, e.g. extending over a year, that sufferers made significant progress in their personal development. Characteristically, their families lost contact with that progress and continued to hold an image of them as they had known them beforehand.
Consequently the family had tended to 'close ranks' without them, so that on discharge they were not easily accepted back into their network, with debilitating results.]

* Reference to the correctional system is but one example of many which may make it clearer that issues to do with mental health care are not bounded by considerations of direct provisions by mental health services, nor by any other governmental agency, nor by any other particular resource.

Hence, if we share the conviction (to follow the rhetoric), as I do, that mental health care has a preventative orientation throughout its functions, then a mental health service must engage with the whole spectrum of mental health issues within the community of commitment, rather than just issues to do with the 'mentally disordered/ill'.

It is within that framework that the best care for the disordered will follow.
Mental *health* must not be allowed to translate as mental *ill health* as is so often the case, even at the 'highest' and most 'educated' levels.

* It is essential in planning to understand the primary reason for the existence of a statutory mental health service. It is *not to do it all,* but to do what only it can do and to see to it that the whole job continues to be done.

The one inalienable responsibility is that mental health services monitor mental health in their communities of commitment and plan with all parties appropriately.
There is no other body given the authority and responsibility to do that essential task. Many can help.

* Finally, 'data collection'.
The lack of foresight and adequate use of existing technologies and available expertise in this area is astounding.

Perhaps planning is going on apace at some national level to overcome this disaster, but if so it is not apparent. If it were going on, then we would all know about it as part of the awareness of those undertaking it to bring us with them in the task.

Individual health services, hospitals, doctors in private practice and other pockets of health care activity have been left to develop their own strategies/software in attempting to implement digital based systems.
Hence we cannot share all this hard work (to say nothing of the available paper based data) in the interests of better health care!

Is it not urgent that a national approach is undertaken to bring all this together?

In the 21st century, to be confronted every day with clinical problems requiring the re-gathering of heath history, for a given individual, on most presentations, and relying primarily on paper records which are not even problem oriented is just plain awful - and can be dangerous.
The waste is obvious in every parameter considered.
This is to say nothing of the alienation of the subject of repetitious interrogations, the potential for research material and so on, when data could alternatively be gathered into one shared data base, continually updated, with the whole 'file' problem oriented and available at any authorised terminal, at any hour.

* A similar problem exists in a more general sense community-wide.
I believe it is not possible to have an efficient mental health service, leaving aside the value to other services, without adequate reference to the resources within the community of its commitment.

Since World War 2 there has been a proliferation of locally based Information and Referral organisations, usually voluntary and often subsidised, which attempt to meet this vital need.

A very early example is the Lane Cove Community Aid Service. Many other Neighbourhood Services, Community Services and so on, with locality name attached, exist all over the country.

In my view, their primary task needs to be the fullest possible collection of readily available data on resources of all sorts, for the use of individuals, organisations, professionals and whoever.
Importantly, and because no one system can know everything, this should include information on where to go for further information and how to 'unlok' systems.
Again, this should be digitally recorded and sharable across the nation - more commonly locally and with neighbouring localities.

Apart from the enhancement of systems, such as mental health, the provision of such a resource is a mental health issue in itself.
So much do I believe this that it was to that task that I addressed myself early in helping 'the few' in pioneering a mental health service in the Central Coast of N.S.W. For lack of anyone else whose usual role may have more readily fitted implementation of such a task, I was able to promote the formation of local information and referral agencies for the purpose.

Just as mental health services may misperceive themselves as an exclusively mental ill health service, so do information and referral services sometimes lose their awareness of the central role of their data collection function.

What often drives this loss of awareness, is that in meeting enquiries, the needs become so much more apparent that energies are displaced into attempting to meet the neediness of the people concerned, while forgetting that many other resources are available, but none is declaring responsibility for the crucial one of resourcing others with data and appropriate referral.

- Donald Scott-Orr, psychiatrist,