Submission to Senate Select Committee on Mental Health

The adequacies 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.

I am a retired administrator, from Melbourne who is concerned for those who have a serious mental illness.

I am presently Chairperson of a Uniting Church Council, and am the carer of a schizophrenic who is now a permanent resident of Australia. This illness limits his employability and destroys his self- confidence. His father is his primary carer, but as his father is not particularly confident in using English, I try to be available to assist whenever the patient experiences problems with his illness and seeks medical assistance.

My friend is about 35 years of age and a member of our congregation who resides alone in a bungalow at the rear of a house located quite close to our church. His parents migrated from South Vietnam when he was about four years of age. He is the youngest of a family of two sisters and one brother. His mother was schizophrenic in her twenties and was cured by ECT treatment at that time.

He developed early signs of schizophrenia during High School at about Year 11. However he obtained his VCE in Year 12, and went on to University to study Civil Engineering. During his second year of tertiary studies he was diagnosed with schizophrenia and broke off his studies whilst undergoing treatment.

He underwent several series of ECT treatments at Box Hill Hospital but was unable to return to full time studies, even though he attempted this, taking time off from his studies over two to three years. He eventually abandoned his studies and remained at home with his parents.

Following a schizophrenic episode at his home, he attempted to burn down his room. As a result of this, his parents felt insecure with him living with them, and organised the self-contained bungalow near our church. He began to attend our church from around this time in the 1990's.

He did not appear to be a danger to others, but we (his parents and I) were concerned about his mental stability in subsequent years. He regularly drove to his parent's home for his evening meal. This was only about three kilometres away. He was safe in his driving for short distances and had no trouble driving to or returning from his parent's home. He also occasionally would drive to his doctor's surgery to attend medical appointments near the local medical centre, and to his local shopping centre to purchase food and other items for his own use.

During 2002, he underwent another schizophrenic episode when he attempted to burn his Bible and other religious books on the floor of his bungalow, destroying the carpet and damaging the floor. He was admitted to a public hospital Psychiatric ward for supervised treatment and ECT therapy. He was hospitalised for several months whilst undergoing medical treatment until his mental state stabilised. He was discharged and returned to his bungalow.

During February 2003, he again began to alter his prescribed dosages of psychotropic medicines and became very depressed. He asked my wife to drive him to the nearest railway line where he intended to commit suicide by laying on the railway tracks. He was

readmitted to the public hospital and began the stabilisation process to balance his medications. About mid-February he walked out of the Psychiatric ward and went out to a main road and deliberately stepped in front of an oncoming car.

He was badly injured, with lacerations to his head and face and a fractured right humerus. It was at this stage that I realized I did not have enough understanding of my friend's ailment and undertook courses with the Mental Illness Fellowship Victoria, on schizophrenia, as well as attending a Beyond Blue Seminar.

I learned about the availability of emergency care for the mentally ill, and made contact with my friend's supervisor at the district health centre. However I did not feel that my enquiries or offer of support for my friend were appreciated or wanted. Subsequent calls when he was experiencing problems were not returned, and on the occasions when I was able to speak to his supervisor, the supervisor did not appear to be willing to spend the time discussing any action I could undertake to assist my friend. I no longer contact his supervisor whenever problems occur.

The District CAT Team have been very supportive, coming to my friend's bungalow when requested by him, after he has experienced difficulties with his medication or been experiencing 'voices' which encourage him to injure himself. On occasions I have tried to be present when the CAT Team calls, so as to support him, but also to learn from their counselling at the same time. The team is very overworked and it is often many hours before they are able to get time to visit my friend.

During 2004, he began to experiment on his own initiative with changes to his medication. As a result he began to experience voices once more and developed suicidal ideation. I drove him to the local public hospital on two occasions for emergency treatment and counselling by the Duty Psychiatrist. Again, the hospital medical staff was very hard pressed to keep up with normal casework in addition to emergency cases, which arrive at all hours of the night. They were able to assist him and later on, to pass on his case notes to his treating psychiatrist.

I believe that the emergency services provided by the Department of Health through the hospital, the CAT Team, and the case supervisors do an excellent job in the time available to them. However it is in the area of emergency and after hours support, which is lacking in availability. I do not know the number of people who are available at nights or at weekends, especially the CAT Team members. However it seems that they are overworked when on duty and unable to meet a reasonable timetable for intervention in emergency, that is to contact the patient within two or three hours.

It is difficult for a lay person to decide whether suicidal thoughts are merely a reflection of the patient's thinking at that moment, or the formulation of a long term plan of self-harm, which is a cry for help. I wish to submit that greater resources need to be allocated to the provision of emergency counselling and home visitation where mentally ill patients have previously voiced intent, or actually attempted self-harm. I cannot suggest numbers of personnel required but suggest that statistically, staff should be able to counsel and visit patients within three hours of notification.

I would be pleased to speak further on my experiences should the Committee wish to interview me further.

Yours sincerely,