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Senate Select Committee on Mental Health Submission

Terms of Reference and Responses

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 Government has failed to publicise its Mental Health Strategy adequately and, apparently, expenditure at this level is dramatically lower than that of comparable countries. As revealed by the 1993 Report of the National Inquiry into Human Rights of People with Mental Illness, both policy and funding differ from State to State. Major changes in the direction of policy by the Queensland Government came about in September 2002. The last statement by the National Mental Health Strategy on the rights and responsibilities was published in 1991. The implementation of the Mental Health Act 2000 in Queensland was well publicised. The Queensland Mental Health Consumer Advisory Group (QCAG) has attempted to act as a link between Mental Health Consumers and carers and the Queensland Government. (All of this was my understanding at the time of writing).

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.

The movement to remove care of psychiatric patients from hospitals culminated in 2004 in the closure of a ward at The Wesley Hospital and of beds at Princess Alexandra Hospital. In order to combat such moves (which may be motivated by nothing but cutting costs) there needs to be an overhaul of the types of accommodation that are available to mental health consumers – for when they are well as well as for when they are unwell. Safe House care for those suffering acutely is already being practised by Dr. Vaidyanethan Kalyanasunderam under the auspices of Queensland Health at Cleveland in the Bayside area of Brisbane. An intervention of this kind strikes at the adequacy of modes of care such as prevention, early intervention, acute, community care and after hours crisis services. More moves towards expanding respite care should follow those already made by the Association of Relatives and Friends of the Mentally Ill.

c. Opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care.

Funding by government of community groups has been difficult to establish. The Brisbane Obsessive Compulsive Disorder Support Group recently achieved it only after years of hard work by its coordinator. At present it may be preferable for such groups to maintain their independence by avoiding government funding. Princess Alexandra Hospital just opened a new facility and then closed beds down almost immediately. Such funding cuts in the public and private sectors are a worrying trend.

d. The appropriate role of the private and non-government sectors.

Private health care insurance, at about $1500 per annum for a single person, opens up the possibility of 'shopping around' for care, a luxury which consumers in the public sector simply do not have. This expenditure is beyond the reach of many on disability support pensions. The role of the private sector is to excel in mental health care. This is despite the fact that private psychiatrist do not often work with a team of carers such as psychologists, social workers and occupational therapists. However they do work with nurses in private hospitals. It has been my experience that the private sector is less traumatising than the public. Non-government groups that focus on the individual in the community

offer valuable therapy for those in the public or the private sector. The emergence of peer support in such groups may have broad ramifications, but implementation is problematical, especially economically.

e. The extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes.

With closures of beds in both public and private hospitals it is indeed time to focus on the social needs of mental health patients. Most importantly, it is debatable as to whether such institutions can be 'there' to meet the urgency of the needs of those at risk. Waiting lists for public housing have blown out to anywhere from three to eight years. Unemployment is no where near the level of the 5% it is in the wider community. Employment is an active sight of sigma. Families often have a very different perspective on the patient's illness from that of the individual concerned. Families can cause problems rather than creating solutions. Social supports should be in place, which offer hope to those involved as well as to their families. Mental disease should be treated as episodic rather than chronic.

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.

In part, the de-stigmatisation of mental illness that has occurred is due to the realisation that mental illness can happen to anyone, anywhere, anytime. Nevertheless, groups of affected people do emerge. Special interest has been focussed on one group of people from the Caribbean whose incidence of mental illness soars if they immigrate to Britain. Once there, this effect will be evident only when they do not live within their own ethnic group. An increased incidence of schizophrenia has been associated with urbanisation in the USA. Children are especially at risk of inappropriate diagnostic interventions. There needs to be much more debate as to whether potent mind-altering drugs should be used on children at all. There are social pressures in some groups, which may precipitate mental illness. Adolescents are maneuvering difficult social genderisation transitions, the aged may be alienated from their own social wisdom, and indigenous groups may be unfamiliar with their dreamtime songlines. People should not be treated as part of a group but as individuals who are socially determined. Such individuals are overdetermined, that is subject to many different influences. We are all complex. How individuals cope with drug and alcohol dependencies will be very different. Where such differences are not as evident there is all the more cause for alarm, as in indigenous cultures.

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

As a retired scientist, I am appalled that positions for mental health nurses appear to by far outnumber positions for scientists. As primary carers, these people for the most part maintain the status quo. Family support groups also tend to support the existing situation. The question that arises is 'Who is going to educate the educators?' Even though there are challenges to the medical model, it is difficult to loosen the hold that biological psychiatry exerts at all levels of primary care. Perception of the need for radical change is not the sole prerogative of any one group. Individuals who share this perspective must struggle to bring about change. Peer support and care may be one way in which such change can be approached.

h. The role of primary health care in promotion, prevention, early detection and chronic care management.

GPs are usually the first stop for those experiencing mental illness and often the last step for those experiencing chronic illness. It is essential that patients should be able to consult with their GPs without triggering an emergency that can only result in a referral to a specialist. There are thirty percent of people who have an episode of schizophrenia who will not go on to have any further episodes. Detection of an early stage and containment at that level may be possible and result in real prevention. Risk may be visible even before diagnosis is necessary. Counseling through difficult life experiences could serve that one third of sufferers who would recover without drug treatment.

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.

All of these measures would increase the possibility of a speedy recovery should they be instituted. Iatrogenesis and recovery-focussed care exist in the shadow of mental health services, which do not acknowledge either of them. Consumer involvement and peer-support represent real hope on a horizon that remains distant and blurred. Education of the mental health workforce will be necessary for consumer-operated services to be introduced. All these measures should be implemented.

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.

Criminal justice should not be confused with the rights of the mentally ill. It is debatable whether there is an overrepresentation of people with mental illness in the criminal justice system and this is a debate we should be having. As a hothouse for stress, the prison system may need to review any tendency it has of inducing mental illness. This raises the question as to whether a prisoner's depression is a condition which should be treated rather than a state which should be endured. Diversion programs would be better in my opinion. It is a human right for a prisoner to be treated; it is a human right for a citizen not to be treated.

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 minimising treatment refusal and coercion.

Detention and seclusion have no place in mental health facilities. This should be non-negotiable. Such inhumane treatment will only enhance treatment refusal. Where does one draw the line on coercion-promoting engagement? For the most part there is only punishment without reward.

l. The adequacy of education in de-stigmatising mental illness and in providing support service information to people affected by mental illness and their families and carers.

Such education is long overdue and can best be instigated by feedback from patients and peer-supported frontline services. Patients need to speak out for themselves and speak up for others.

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.

This is a huge question. Mental patients have been sold out on the issues of housing and employment. Law enforcement is a problem when police shoot first (to kill) without asking questions. The general health of mental patients deteriorates due to drug side effects. Most GPs and psychiatrists are in denial about this.

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

Australia is well behind other comparable countries in how much is spent on mental health. No doubt we also lag behind in expenditure in mental health research, despite Australia being a leader in medical research. Today, patients live without hope of recovery. The hopelessness of current mental health research has led many to look to non-medical models of the problem. Drug companies are only

interested in adding additional drugs to the arsenal used to treat mental illness. Social intervention has shown that exercise is as effective as drugs in treating depression. Cognitive therapy is also being introduced as an alternative to drug therapy. Other alternative therapies such as vitamins and acupuncture may also be relevant but are expensive. If biological theories are as relevant as consensus would have, then much more money should be targeted at further understanding popular theories such as the neurotransmitter theories. It is still not known how high and low levels of serotonin affect well being or how high dopamine levels produce a heightened sense of awareness. Many voices making little sense produce the toxic state in which research currently exists.

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

Close scrutiny of current methodologies will not improve them. Patient's medication should be constantly reviewed and cessation of treatment should be introduced as a possibility after five years. Long term side effects beyond five years of treatment are a grey area at present. Initiatives for evaluating mental health services in terms of quality should emerge from within the psychiatric and medical communities and be challenged by others outside these communities. There should also be consumer-review of services. It is imperative that standards should to monitored internationally by such bodies as the World Health Organisation and those responsible for DSM-IV with as much vigour and rigour as possible.

p. The potential for new modes of delivery of mental health care, including e-technology.

Existing internet technology means that information about all facets of mental illness is readily available to individuals and interested groups. This information crosses existing state and national boundaries and functions at a truly international level. To this extent, health care and information technology form an alliance with the strength to challenge the functional chaos known as mental health research. Computers have already revolutionised medical research. The net is a place where non-medical models of mental disorder can thrive or wither, a place where they can stand on their merits. The contacts developed by e-mail could bring urgency to the need for change. What is necessary is that we do not forget what human rights are as we are caught up in this information whirlpool.