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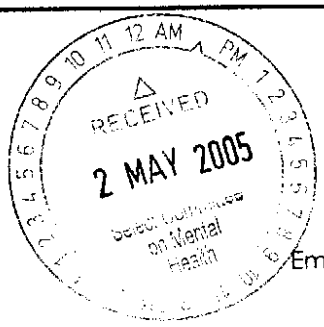

The Secretary
Senate Select Committee on Mental Health
Parliament House
Canberra
ACT 2600

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Submission to the Senate Select Committee on Mental Health

This submission may represent a viewpoint different from most, in that I have only watched and tried to deal with the system from the sidelines, not from inside institutions.

After brief experiences working in several psychiatric wards, I was a GP in various rural and remote areas of Australia for many years until felled by a stroke. My long experience of being a police doctor and gaol visitor was useful after my partial recovery, and enabled me to set up a small practice in Mt. Gambier, SA looking after the traumatically stressed.

In particular I saw sexually assaulted adults and children, mentally ill people trying to survive in the community, victims and perpetrators of domestic violence and child neglect and some criminals, survivors of wars, disabled and poverty stricken people and refugees.

Many had been traumatised since early childhood, and often had developed, at least, personality disorders which made their behaviour difficult for others and confusingly unhappy for them. Some had episodes of frank psychosis requiring brief hospitalisation, or went to gaol, or were homeless or cared for by aged parents and untrained, unhappy families.

Enclosed are a few highlighted articles for those of you who are not yet aware of the huge but muffled controversy raging within psychiatry over:

- drug vs. social therapy for severe symptomatology,
- the powerful drug company/ institutional psychiatrist symbiosis (social therapy uses cheaper employees and can sideline psychiatrists if they are not careful), and
- The growing awareness of the severe danger of overuse, prolonged or careless use of antipsychotic and antidepressant drugs, which seems to be rife within institutions.

Many of your terms of reference fall outside my experience or skills, and you will have to look elsewhere for statistics, but I have met and tried to help many people over the years and discussed the system with lots of health professionals inside and outside the institutions, so perhaps I have a broader view than some.

It is obvious to everyone that the outcomes of the mental health system are deficient by any first world standards, hence this committee. Funding has been inadequate for good results for at least two decades, probably more. Other people know the details better than I, so I prefer to focus on another aspect, the happiness of both staff at work and the patients.

In my opinion very little attention is paid to the comfort and convenience of staff or patients in our system, yet we all theoretically acknowledge that workplaces where staff are happy inevitably have greater efficiency and loyalty and treat patients with greater care and sympathy than the current unhappy, resentful, vastly overworked people trying to heal patients.

Yet work morale depends far less on funding than it does on adequate training (by its results, current staff training has to be seen as very inadequate), facilities such as in-house child care, sorting out the present idiot system of nursing rosters, cutting down paperwork, night staff parking in less dangerous areas and improving communications between and within departments. Easy to say, hard to do unless the Chiefs are required to listen to and take notice of what the Indians say.

The coalface staff and patients usually know what is going wrong, and often have good ideas on fixing the problem, but who listens?

Also, some people are not very good at dealing with people, and much as we might hope they will improve, there needs to be some test or longstanding history of consistent kindness before any staff is allowed to deal with the emotionally fragile public or other staff.

There are jobs in the health system that do not involve lots of personal contact, to which people without highly developed interpersonal skills can be sent.

The rest, especially inexperienced medical and nursing staff (and those with already obnoxious reputations who fall under a sunset clause in new legislation) would benefit enormously from the right type of community building training, not usually available to them now but available in the wider community.

Doctors typically have a big say in what mental health training goes on and unfortunately they are typically way behind and very conservative in that area.

Big business trains their people in management skills once they reach a certain level. If mental hospitals already do so, it is not obvious by their results. How about employing and sending independent and imaginative trouble-shooters regularly to all the institutions to look out the bottlenecks, mistakes, glitches, resentments and so on, and with the authority to do something about them?

Patients are often too cowed to complain to staff. They know that despite the lovely list of patient rights and responsibilities that they receive, they are entirely at the mercy of staff, who may well be persistent sadists, uncaring, ignorant of their medical or personal histories, burnt out, exhausted after ridiculous shifts or maybe just having a bad hair day. Not to be depended on for consistent kindness or efficiency. This is not intended as a slur on all the kind and patient people who somehow manage to struggle on.

There is lots of evidence to suggest that people's mental health improves markedly and consistently if they are surrounded by people who treat them as though they are worthwhile, lovable individuals who have a valuable contribution to make in their communities. In my experience that situation is rare in large institutions, and applies to both staff and patients.

Re prevention, early intervention, community care, after hours services, and respite care: - non existent or very rare in all the rural and remote places I have worked. Even acute care is very difficult to access, given the lack of psychiatric beds, nursing staff and psychiatrists in country areas.

Sending acutely psychotic patients to the city for care a few years ago typically involved a police paddy wagon (with psychiatrically untrained police officers) and a revolving door policy at Glenside Hospital in particular, which saw the sedated patient back in town the next day.

What then? The family can't cope; there is no suitable accommodation, in spite of Anglicare's best attempts, because the wider public are scared of living next door to mad, bad, foreign, indigenous or disabled people.

That leaves gaol, unsuitable and scarce boarding houses (if any) or under bridges, since there are no houses or funding for 3-4 people and a carer under one roof. For many of the people I have seen small group accommodation with or without a live-in carer may provide the best option so far. Surely that is not a huge added expense, given all the money that was to be spent on community mental health after, for example, the Richmond Report?

I have lived in various third world countries that seem to do a lot better with their mentally ill than we do. In part, they rarely have public funded welfare systems, so ill people are expected to work if and when they can, which probably increases their confidence in themselves. Usually the extended family care for them.

They are more in the public eye than ours are, therefore there seems to be more social acceptance and less ignorance and stigma, and typically they live in communities which take more responsibility for their welfare than we like to do.

The concept of confidentiality is a big obstacle to patients, their relatives and friends and community staff, apparently being used mostly by central bureaucrats to cover their backs legally. I remember sending a sexually abused little girl to the child protection unit for diagnosis and not receiving a report when she came back, on grounds of confidentiality. Since I was going to be the ongoing treating doctor that was a ludicrous decision, which was not changed despite numerous appeals to higher authorities.

There are other issues, such as involuntary detention, which other people can deal with better, but very much the outcome of detention and all other methods of dealing with vulnerable people depend on the kindness with which they are consistently dealt with by staff.

Staff can best work effectively if they find themselves in congenial surroundings, if their work needs are met, if they are treated with respect and

hopefully affection by management and each other, and if they have worked on their own mental health inadequacies to the point where these do not get in the way of their work.

In conclusion:

If we who are involved in the mental health of the country can lead by example, placing kindness and compassion at the basis of all our work, way before economic and other considerations, we may be able to develop a society which can point the way to a nation which has been made cynical by the greedy and cynical people who lead us.

Australia's traditional valuing of egalitarianism has been eroded away by the behaviour, especially during the last decade, of our leaders, and that of American leaders, who appear value nothing above money and personal power, and have a peculiar belief in their own superiority. I would love to be proven wrong and think the mental health community in this country can lead the way.

Our citizens have a relatively enviable way of treating each other compared with many other peoples whose levels of social tension seem more explosive. We in the mental health field are in excellent positions to lead the way world wide towards a more healthy and peaceful society by ensuring a higher level of emotional wellness in all our citizens, and by educating our children to be mentally fitter.

Yours faithfully,

Alice Caseleyr.