Health Services Union

May 12, 2005

The Committee Secretary
Senate Select Committee on Mental Health
Department of the Senate
Parliament House
Canberra ACT 2600
Australia

Dear Sir/Madam,

Please find enclosed the submission of the Health Services Union to the mental health inquiry. Representatives of the union are available to give evidence to the committee during its hearings if required.

For any further information please contact me in the union's national office on 03 93413328.

Yours Sincerely,

Craig Thomson
National Secretary

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Submission to the Senate Select Committee on Mental Health

WHEN DEMAND EXCEEDS SUPPLY

Mental health services in Australia

Executive Summary:

Australia's mental health system remains dysfunctional and under-resourced. That is the evidence from the people who know – the mental health professionals who work every day to deliver the best possible care to hundreds of thousands of people around the country.

The integrated mental health system envisaged under the National Mental Health Strategy has not eventuated. Instead what remains is a crisis, reactive model of care with obvious gaps in the provision of services.

Where mental health services are lacking the pressure goes onto other areas of the health system – to the ambulance officers, the emergency department and community health care professionals who are ill-equipped to handle the mentally ill.

The consequence is that we are failing to properly treat some of the most marginalised and needy people in our society.

The gap between the rising demand and the provision of services also has ramifications for a workforce trying desperately to deliver quality care with insufficient resources. Working in mental health in many cases is becoming a more stressful, more dangerous and less fulfilling job.

Workforce training and planning remains inadequate despite repeated warnings by the union. Strategies to deal with a rapidly ageing nursing workforce through better undergraduate training and recruitment have not been put in place.

This inquiry represents an opportunity to look again at the provision of mental health services. What is required is for the gap between public expectations and the reality of services to be narrowed.

Leadership and increased resources are required from the Commonwealth and State Governments. Mental health needs to be brought to the centre of health funding and planning considerations rather than the periphery where it sits today.

National mental health reform needs to:

1. Develop a national mental health strategy that does not leave large groups of the Australian community without access to adequate mental health services.

2. Expand the level of funding for mental health services to be proportionate to the disease burden it imposes on the community. The HSU believes that funding needs to increase to at least 20% of total health expenditure.

3. Address the workforce supply and education and training needs of the mental health work force. Failure to do so will frustrate the implementation of policy, initiatives and/or strategies in relation to mental health.

4. Mental health nurse training at the undergraduate level should be reformed to provide for specialisation/streaming. Mental health nurses are not provided with adequate theory or content at the undergraduate level to fully prepare them for beginning level practice in psychiatry.

5. Coordinate the national mental health strategy and the national drug strategy

6. Implement measures to ensure that families who provide care to relatives suffering a mental illness are recognised and supported.

Background

The Health Services Union is a specialist union with over 70,000 members working in the health and community service sectors throughout Australia. The membership of the union includes, psychiatric nurses and other nurses (hospital, university and VET trained), mental health staff, health and disability workers, allied health professionals such as clinical psychologists, psychologists, social workers, occupational therapist, physiotherapists and radiographers, ambulance officers, clerical and administrative staff, managers and support staff.

The union has significant representation in the health, aged care, mental health, disability and drug and alcohol sectors.

This submission has been completed after extensive interviews and consultation with members working in all areas of mental health, particularly those specialists in the field who are members of the HACSU branches in Victoria and Tasmania.

Mental Health in Australia

The World Health Organisation identifies mental health as one of the world's leading causes of disease burden. By 2020, it is estimated, depression will be the leading cause of disability in Australia.

The National Survey of Health and Wellbeing conducted by the Australian Bureau of Statistics reveals that one in five Australians will be affected by mental illness at some stage in their life. Australia also has one of the highest youth suicide rates in the world (SANE Australia).

Mental health is a major health issue for our society. In the past the impact of mental illness on Australian society has been underestimated and the provision of services neglected.

In recent years the reform process has helped raise the profile of mental health as a health issue. However concurrent with this reform has been the development of an increasing gap between public expectations and the reality of services provided.

The mental health system in Australia is currently in disarray. Besieged by rising demand and starved of an adequately trained workforce the system constantly breaks down contributing to the personal horror of many Australians coping with mental health problems and disorders.

Since the late 1960's deinstitutionalisation has been a major plank of this reform process and is being implemented to varying degrees across the country.

This process needs to continue with the development of an accessible range of community and bed based treatment services to replace the institutions. In addition vocational, accommodation and support, self help, educational and rehabilitation services need to be provided alongside clinical treatment to make deinstitutionalisation work.

In some parts of the country these service systems exist or are developing. However this reform has not meant ease of access to services.

The lesson of post deinstitutionalisation is that demand must be also managed to allow people access to service. In Victoria where the most comprehensive suite of treatment and psychosocial support services exist demand has outstripped supply.

The evidence of this rising demand and consequent unmet need has been well documented, both anecdotally and in studies and reports. The formal reports are well known and this submission will not detail the National Survey of Health and Well Being and the various 'Burden of Disease' studies.

However, in the context of rising demand it is worth noting that the 'Global Burden of Disease' study projects by 2020 mental health conditions will increase as a share of global burden by a further 50% on current figures.

Statistics and epidemiological forecasts are not the only evidence of the current failure of mental health care in this country.

Throughout the country there is abundant evidence of the strain on the existing mental health service system and the 'flow on' effect into the wider health and community service sectors. Members report emergency departments overwhelmed with people with mental health conditions and families unable to access help until crisis point is reached.

Constant calls for service improvement come from sources as diverse as police and ambulance associations to former bureaucrats such as the Chairman of the Australian Consumer and Competition Commission.

People with mental health problems do not go away when they are unable to get the assistance they need. They usually go elsewhere. In other areas of the health industry HSU members in ambulance services, general hospitals, aged care facilities and drug and alcohol services increasingly have to provide some form of assistance to people with mental health problems.

No matter where you work or live some evidence of these problems will be obvious. The city worker can see the mentally ill homeless on the streets of any major Australian city.

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 Mental Health Strategy guides Australia's delivery of mental health services. While the strategy initially was innovative and drove major reform it has been neglected.

In recent years leadership from the Commonwealth Government has evaporated to the degree that it is 'missing in action'. The clearest example is the third national mental health plan. A policy document that no one disagrees with, however in reality is little more than another report to gather dust. The necessary financial commitment to support the 'plan' has not been provided.

There is great concern within the sector about the apparent disinterest and lack of leadership in the area from the Health Minister Tony Abbott and the fact that a branch solely devoted to mental health in his department no longer exists. (Sane Mental Health Report 2004)

Effectively the Commonwealth has abandoned the States to progress mental health reform in a way they are best able.

> *"Of most concern is the frequent feedback emerging from consultations with consumer and carer representatives that the Strategy's vision of accessible, responsive and integrated mental health services has little resemblance to the current reality in many areas of Australia."* (Out of Hospital Out of Mind: A report detailing mental health services in 2002 and community priorities for national mental health policy for 2003-08. Mental Health Council of Australia)

In areas of the Commonwealth Government's direct responsibility there has been patchy performance. The Commonwealth funded specialists who are private psychiatrists are only accessible to a very limited few. Generally they are concentrated in the affluent suburbs of the major metropolitan cities and access to that service system is usually dependent on a capacity to pay. If you live in outer suburbs of the major metropolitan centres or rural and regional Australia these specialists are not readily accessible.

MBS figures show that people in non-metropolitan areas, particularly in rural and remote communities, are less than half as likely to receive services from a private psychiatrist than people residing in capital cities. When people in rural and remote areas do see private psychiatrists, they are likely to have only two-thirds as many consultations. (National Mental Health Report 2004).

Even their fellow medical colleagues are unable to get service in a systemic way. General practitioners, traditionally the biggest medical providers of mental health services in community settings, have not had access to adequate referral consultation and supervision services from the private psychiatrists.

An American multi national health company has been bought into Australia to provide a phone and internet based consultation service to GP's.

In spite of the significant funds paid through Medicare the contribution of private psychiatrists is minimal and totally out of proportion to the public funds expended.

It is worth noting that if a situation similar to this were to arise in any other field of medicine, especially one with a comparable "burden of disease', cancer treatment for example, it would provoke a national uproar.

Could a situation be envisaged where oncologists refused to provide more than a very limited referral and consultation services to general practitioners? Or only provided treatment for certain types of cancer, stating that other types of cancer was a state responsibility? Bizarre though this seems this is the situation with mental health.

The Commonwealth mental health primary care system (general practitioners) has only just begun to recognise mental health as a health issue and GPs can now bill Medicare for a mental health consultation.

However unlike other Medicare items, the mental health item is severely restricted. The Commonwealth has set a limit on the amount of mental health work a GP can do. Given demand clearly exceeds this cap more people again miss out.

Whilst the National Mental Health strategy is sound and the framework for policy delivery is sound with the absence of properly resourced and funded services that have the capacity to meet demand and a well trained workforce the desired outcomes of the strategy will not be achieved.

> *"The clear message from the community is that people continue to experience problems in accessing services during crises and finding services that are responsive to their individual needs."* Christopher Pyne MP, Parliamentary Secretary to the Minister for Health and Ageing.

No government in Australia, State or Commonwealth, has as yet fully recognised its responsibility to the Australian community and responded to this problem. Instead the familiar blaming of each other citing complex commonwealth-state arrangements or 'cost shifting' is heard. The reality is both levels of government are not fulfilling their responsibilities.

This submission therefore will focus on the experiences reported by our members working across a full range of mental health services.

Lack of capacity/funding/resourcing

At a sector level mental health is comparatively under resourced. It is also experiencing unprecedented workforce issues, and a lack of primary and early intervention community support services.

Mental health represents approximately 20% of the illness burden. However, in 2002/2003 approximately 7% of the federal health budget was committed to mental health.

It is important to note that total spending on mental health increased by 62 per cent between 1993 and 2002. But although this growth was significant the increase paralleled that in the overall health sector. While mental health has maintained its

position it has not increased its share of the health dollar despite the obviously low base and the rapid increase in demand. (National Mental Health Report 2004).

In addition, the significant disparity of funding that existed between jurisdictions at the start of the National Mental Health Strategy has not been eradicated. In 2001-2002 per capita spending on mental health by the states and territories ranged from a high of $110.82 in Western Australia to a low of $84.83 in Queensland. (National Mental Health Report 2004)

- Nobody in the mental health sector believes the current acute bed day rate actually meets the cost of running an inpatient unit and services redirect community funding to cover the shortfall.
- There is a chronic shortage of beds - both acute and psychiatric disability support. The adult acute mental health system is operating at “unsustainable occupancy rates of over 95 per cent in Melbourne’s metropolitan hospitals.”
- Patients are admitted to overcrowded psychiatric inpatient units at times having to sleep on mattresses on the floor or be placed in seclusion rooms.
- There are limited supported discharge options for patients into the community or into rehabilitation focused inpatient beds. This creates a backlog in acute units and further adds to the pressure on acute inpatient beds.
- Community and triage clinicians are overwhelmed by high workload and caseloads, providing only crisis response and dealing with those with the highest level of acuity.

The mental health budget should reflect the level of service and demand for service, ie the illness burden, and **in the longer term be funded at 20% of the overall health budget.**

That would bring Australia closer to the levels of other Western nations including the USA (19 per cent), the Netherlands (23 per cent) and Great Britain (22 per cent).

Increasing demand has reduced access to services, especially in crisis situations, overloaded community clinics, ever growing waiting lists and insufficient acute beds

are now commonplace. Increasingly the service system becomes less proactive as it struggles to cope with a constant stream of crises.

The constant flow of media reports, 'horror stories' experienced by people attempting to access a service, a steady stream of negative coroner's findings, reports to state parliament and calls for action from community groups are now commonplace.

Lack of mental health beds

Around the country, the union's members report bed shortages in each state and territory. Despite the increase in demand, the overall number of acute psychiatric beds available in Australia has remained relatively unchanged since 1993 at approximately 3,700. (National Mental Health Report 2004)

Overall the number of psychiatric beds in the public sector fell by 26 per cent (2,057) between 1993 and 2002 with the major fall in bed numbers in non-acute units (53 per cent).

Major disparities continue to exist between the states and territories. In 2002 the Victorian Auditor General reported that Victoria had approximately 21.8 acute mental health beds per 100,000 population – 2.6 (or approximately 130) below the national average. The Auditor General found the number of beds in Victoria has been constant since 1996. This is despite a 20% increase in demand.

It is now commonplace for mental health clinicians in Victoria to spend up to six hours on the phone trying to locate a mental health bed for a person in crisis.

It is reported to the union that such occurrences can be as regular as two hours a day, leaving patients in emergency departments for up to two days and requiring mental health clinicians to remain with them and not able to respond to other calls.

It is also a frequent event for a client to be transported several hundred kilometres for a bed, usually from rural/regional to regional/metropolitan areas.

Inevitably there are no beds in the state. I have had to send people as far as Bendigo to get them into a hospital bed. I am reluctant to send them any further because it is hard on them because don't have the support they need close by.
Angela Gallagher, Melbourne psychiatric nurse

In NSW it was reported in 2002 that 11 of the 17 Area Health Services, with a population of 2,714,613 adults do not provide non-acute psychiatric beds and total psychiatric beds declined from 12,000 in 1970 to 2,100 in 2002. (Mental Health Services in NSW, NSW Legislative Council Select Committee on Mental Health, final report, December 2002).

Members in NSW report long delays for patients with stays of one of two days in an emergency department not uncommon. Registrars often spend several hours trying to find the single remaining bed in Sydney.

In the regional city of Newcastle the major mental health facility, James Fletcher Hospital has for some time had a relaxed attitude to "going over numbers" occasionally. More recently this has become the norm, members report.

Community case loads

For community clinicians caseloads have become so great that staff are reduced to a revolving door of crisis management. A high proportion of long-term, high need consumers are using the community clinical services and home based outreach and day program services, thus limiting the capacity of these services to take on new clients.

Community caseloads for community based workers must be sustained at reasonable levels to allow for proactive intervention that can assist 'recovery' rather than merely maintain people in the community.

Again there are huge variations in the spending on community services in the states and territories. In 2001-02 there was a more than 80 per cent difference between the highest and lowest spending jurisdictions.

In NSW is its not uncommon for case manages to be looking after between 50 and 60 clients. In Victoria, in some instances clinicians have reported case loads of up to 90. Families report distress at not being able to access the help they feel they require.

Work force

Recruitment and retention

> *"Workforce issues, including supply, distribution and quality, remain problematic for all jurisdictions." Christopher Pyne MP, Parliamentary Secretary to the Minister for Health and Ageing*

Resource problems are compounded by serious workforce issues. The supply of new graduates from all the health professions into the mental health sector is low, nursing in particular. It is estimated that nationally only 4 per cent of new graduates are entering the mental health system. Of those who do enter many quickly leave. Many parts of the workforce are now dependent on attracting overseas trained graduates.

According to the Victorian Department of Human Services in the recently released (November 2004) 'Nurses in Victoria: A Supply and Demand Analysis 2003/04 - 2011/12, its own calculations reveal mental health has a nursing deficit of approximately 480 (Division 1, 2 and 3 nurses). Based on current demand of 2,228 the current 'full time equivalent' shortfall of 480 represents a deficit of 21.5% and will exponentially get worse as demand and services grow.

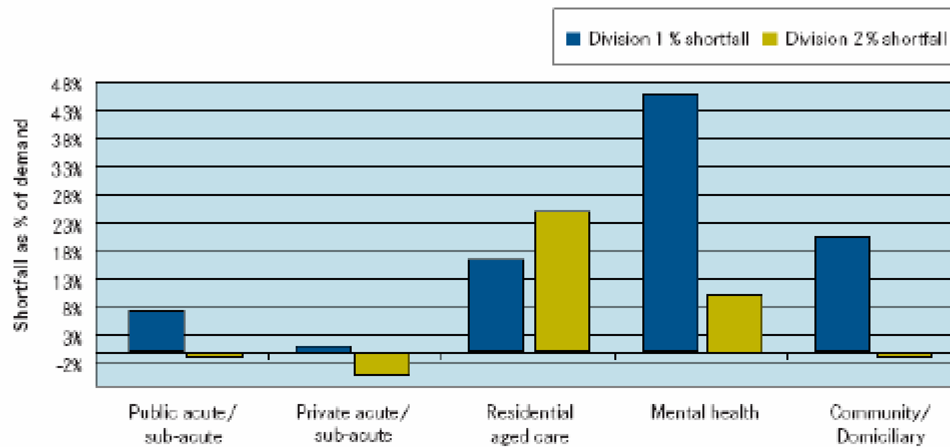
The average age of for example psychiatric nurses is 46. The bulk of these nurses are made up of graduates of the former direct entry psychiatric nursing courses (ie specialised three year courses with between 18-24 months dedicated specialist psychiatric nurse training). This pool of specialist, trained nurses is diminishing as they leave the work force. The consequence being a reduced workforce, but an even more diminished pool of specialist trained psychiatric nurses.

It is projected that the above deficit will be in excess of 1300 by 2011/12, a shortfall of 45 per cent.

Extract from 'Nurses in Victoria A supply and Demand Analysis 2003/04 - 2011/12:

Whilst not the largest sector, by 2011–12 the residential aged care and public mental health sectors appear likely to face the most serious challenges as the workforce demand is well in excess of supply projections.

Forecast Nurse Supply Gap 2011–12: Percentage of Demand by Sector



The Royal Australian and New Zealand College of Psychiatry is also consistently failing to match targets of 120 trainees per year and the rates of new college fellows are insufficient to sustain, let alone expand new mental health services.

In NSW and Victoria in 2004 there were 50 per cent of the required applications for first year training positions.

The College is not directly accountable to government or health services for how it recruits, allocates and trains trainees.

It has undergone a major recent review of its curriculum, training and examination program and has adopted a number of improvements.

But there remains deficiencies, particularly in developing a comprehensive accreditation process which provides feedback for mental health services for ways of improving their training regimes.

> *"Many trainees are now forced to work on crowded, busy, acute adult inpatient units, where the disorders are generally restricted to 3 or 4 diagnoses, the patients are chronic and almost impossible to treat and the focus is mainly on the biological therapies."* Dr Anthony Llewellyn, Staff Specialist, NSW.

Undergraduate Education

In all areas of the mental health workforce, particularly allied health and nursing, significant issues exist in both attracting and retaining a skilled workforce. At the heart of the recruitment problem is the lack of adequate undergraduate preparation and as a consequence a lack of confidence in new graduates in their capacity to work in a mental health setting.

Nursing training at the undergraduate level is failing to produce a skilled and confident psychiatric nursing workforce.

The cessation of specific psychiatric nursing education is the major reason behind the shortage of psychiatric nurses. Currently insufficient numbers of newly graduated nurses can be attracted to work in mental health settings.

> *"It's hard to attract young nurses into psych units. Under the university training system a lot of kids seem to be directed towards general nursing and they don't get the experience or the training in psych."* Bill Deegan, Psychiatric Nurse, Victoria.

There needs to be a comprehensive workforce strategy that addresses both the specific needs of the mental health workforce and the needs of the broader health and community service sector workforce.

Significant challenges exist to achieve a mental health workforce that has skills, knowledge and attitudes required for working in current services and into the future.

There is an absence of a state and national approach to the workforce, including recruitment and retention issues. This remains a key barrier to deliver on the National Mental Health reform.

Undergraduate courses need to be reformed to provide for comprehensive mental health content in all undergraduate courses that prepare health and community service workers.

To this end models of undergraduate nurse education that provide specialisation/streaming should be explored.

While the states have significant influence over course content and can influence this in their own right; the Commonwealth and the state governments should cooperate to achieve the necessary reform.

Moreover, undergraduate nursing courses must be reformed to allow for increased mental health content through specialised streaming and direct entry options.

Additionally:

- Postgraduate mental health qualifications must be developed in areas of sub specialty practice, i.e. community mental health or aged persons mental health;
- The pool of health workers from indigenous and culturally and linguistically diverse (CALD) backgrounds must be expanded;
- Barriers that exist which limit the capacity of current employees in participating in undergraduate and post graduate courses must be removed, eg. enhancing access to training schemes and provide support for learning and development opportunities.

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.

Significant challenges exist to achieving a mental health system that can meet the needs that exist in the Australian community. These challenges are identified as:

- Early identification and appropriate treatments of mental illness in order to further decrease the rates of suicide in our community;
- Clinical service levels to be more tightly defined to enable benchmarking of caseload limits without consumers being inappropriately exited from services to achieve workable caseloads;
- Refocusing on suicide prevention strategies to improve continuity of care post discharge.

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.

Despite some increases in funding, some states still lag behind others, but on the whole Australia compares poorly internationally.

Mental health represents 20% of health cost but the commonwealth funds at 7%, while the Victorian government allocates approximately 10% of its health budget to mental health.

The funding and organisation of mental health services requires significant restructuring to ensure that budgets are utilised in an appropriate manner and to ensure that the long term client goals are as important as the immediate objectives.

To meet the needs that exist in the Australian community funding needs to be increased to a level where an acceptable level of psychiatric treatment care and support can be delivered.

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

Community support services should complement clinical services.

For this to be effective Australia needs a properly funded non-government sector that provides accommodation, rehabilitation, outreach and other community supports.

Currently the sector only receives approximately 5% of the mental health budget nationally.

The clinical services provided by the stand alone facilities can be delivered through a community focused clinical service. However the other and equally important needs for accommodation, social structures employment and meaningful activity must be provided through a developed non-government sector.

To achieve this there needs to be:

- Education and training to provide high quality rehabilitation services;
- A systemic plan for the provision of services;
- Liaison systems between clinical services and the non government sector.

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

Supported accommodation, employment, family and social support services are woefully inadequate. In Western Australia for example supported accommodation is extremely limited with funding 80 per cent below the national level.

Around the country short term rehabilitation focused services (Community Care Units, CCUs) constantly face obstacles to discharging patients who are ready for discharge but are frustrated in doing so because of the lack of appropriate accommodation both in terms of cost and level of support.

To compound this CCUs often receive inappropriate referrals simply because patients need accommodation and the CCU is seen as quick fix. In one Melbourne based CCU in April 2005, there were six patients waiting for CCU assessment beds

but unable to be admitted due to staff shortages that had already resulted in the assessment beds being closed for the preceding 4-5 months.

At the same time there were another six patients waiting to be admitted to its rehabilitation beds but were unable to do so for the same reason.

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.

Child and Adolescent Mental Health

Approximately 25% of the population is under 18 years. Of the 7-10% of the health budget is directed to mental health, in Victoria at least only 7% of the mental health budget is directed to child and adolescent mental health.

This is despite demand for child and adolescent mental health services increasing. For example in one major Melbourne child and adolescent service alone admissions have increased from 80 in 1995 to close to 300 in 2004-2005, with out of area admissions at around 4-6 per month, indicating a lack of regional child and adolescent mental health beds/services.

There is a general shortage of High Dependency Unit beds. In Victoria there are only eight.

This is leading to inappropriate admissions of children and adolescents requiring specialist mental health treatment and support to adult mental health units or general hospitals. This is particularly the case for rural young people.

Adding to the staffing and recruitment (workforce) crisis already referred to, for sub-specialist areas like child and adolescent, the lack of experienced clinicians, especially nurses is having a further detrimental effect. Experience and skills are

needed for family therapy, group work, individual work, CBT, child and adolescent mental health assessment.

There is very little appropriate housing and support for this age group. This means that stays/admissions as inpatient are prolonged for young people.

Many services do not provide after hours child and adolescent assessment teams/services for people under the age of 15. They rely on mental health assessments to be done in accident and emergencies or by CAT teams with limit child and adolescent experience, leading to a drain on those services, not allowing them to do what they are funded for.

Research is required to ascertain whether suicide rates drop when children and adolescents receive help. The observation reported to the union by at least one clinician of 12 years experience in child and adolescent psychiatry is that he is at least unaware of any post discharge suicides by patients he has cared for.

Prevention is the key to child and adolescent psychiatry. Child and adolescent is a very labour intensive area of psychiatry. With early intervention and treatment there is less disruption to the person's development and their schooling, which can have life long effects and cross-generational issues. It helps keep families together and functioning. If the issues children and adolescents are dealt with before forming into a major mental illness there are long-term benefits to the person, family, communities and the health budget.

> *"The biggest problem we see is the lack of support for young people in the community. There are major issues trying to get follow up services, family therapy and accommodation. There is no day program for the kids so they have to go back to school if they fit in or not."* Paul Healey, Psychiatric Nurse, Melbourne.

Child and adolescent mental health services must continue to be built up and not allowed to suffer the near collapse that adult services are currently experiencing.

Alcohol and drug services

The impact of drugs and alcohol on emerging and existing mental health conditions are yet to be properly understood. In combination mental illness and drug abuse can almost guarantee the individual will have the worst possible health outcomes and the most problematic family and social situations. However the service systems in Australia have been slow to recognise this.

Drug and alcohol services work in isolation from each other and the drug and alcohol treatment skills of mental health workers are not sufficiently developed. A capacity to work with drug and alcohol issues should be part of a mental health worker's core skills. Currently it is not.

The Commonwealth government, whilst recognising the problem exists, has done nothing other than window dress around the respective national strategies - window dressing that has not had any discernable impact at the service delivery level.

Current Victorian figures show just under 50% of clients have a drug and alcohol problem and approximately 25% of clients have two or more mental health problems, for example schizophrenia and depression. (Mental Health Three Year Outlook 2003/04 to 2006/07 Victorian Department of Human Services, 2003).

The closure of tertiary alcohol and drug services intervention beds and competitive tendering has resulted in a fragmentation of services as providers were forced to compete and cut costs rather than work together in reaching cooperative benchmarks and industry service standards.

The shift away from tertiary intervention and the focus to primary intervention (education and research) is characterised by community based short stay residential withdrawal services and community based, low staffed, low intensive supported accommodation beds.

Existing residential beds are now primarily focused on those with the highest acuity and those who are also in contact with the criminal justice and mental heath service systems.

There is an urgent need for more resourcing and coordination of services on the full continuum of drug prevention and treatment, including medium intensive residential services for post detox treatment and support.

Mental health services and alcohol and drug services need to be integrated. The government must develop innovative and integrated strategies that coordinate the alcohol and drug interventions provided by all relevant services, particularly:

- Develop the capacity in mental health services for the delivery of alcohol and drug interventions; and
- Improve the coordination and collaboration between drug and alcohol and mental health services.

Aged Mental Health

The population is ageing. As a consequence there is an increasing prevalence of dementia and aged mental health generally. Aged mental health services will impose an increasing social and economic burden on the service system.

Accordingly, resources need to be dedicated to ensure services can sustain aged mental health within the community. This includes adequately resourcing community mental health services and support to families and carers.

Remote & Rural needs

Remote and rural mental health services experience an exacerbated recruitment crisis of mental health professionals. Many for example are unable to recruit psychiatrists. Many services rely on the psychiatric nurses and mental health professionals of the institutions that existed in their regions prior to de-institutionalisation. However, with the ageing populations of for example psychiatric nurses, this pool of specialist, trained professionals is diminishing as they leave the work force.

The Commonwealth-funded specialists who are private psychiatrists are only accessible to a very limited few. Generally they are concentrated in the affluent suburbs of the major metropolitan cities and access to that service system is usually dependent on a capacity to pay. If you live in outer suburbs of the major metropolitan centres or rural and regional Australia these specialists are not accessible.

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

Carer support systems require strategies that incorporate initiatives such as:

- Family Sensitive training for all mental health professionals
- National implementation of Family therapy programs.

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

I. Opportunities for reducing the effects of iatrogenesis and promoting recovery-focused care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated.

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.

There is significant stress on forensic mental health beds. For example when the major Victorian forensic mental health facility, the Thomas Embling Hospital, was established the assumptions at that time were based on an unrealistic assessment of projected prison population(s) of forensic mental health clients.

To compound this situation, the enactment of the Crimes and Mental Impairment Act (Victoria) has seen the courts increasingly refer to the forensic services. This creates extreme pressure on, and a shortage of forensic beds. Consequently, people who are in need of specialist forensic mental health services are remaining within the prison system.

In NSW it has been estimated that 46 per cent of inmates at reception have a mental disorder and the prevalence of psychosis is 30 times greater than the norm. (Sane Mental Health Report 2004).

There is also no secure forensic hospital outside a prison in NSW. It is the only state to incarcerate forensic patients; a situation a parliamentary inquiry found was both extremely rare in the Western World and a breach of the United Nations Declaration of Human Rights 1948 and the NSW Mental Health Act 1990. (Mental Health Services in NSW, NSW Legislative Council Select Committee on Mental Health, final report December 2002).

Accordingly, there is a need to expand the number of available beds within the forensic mental health systems.

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.

Seclusion can be effective in reducing stimuli and an effective means for containment when considered clinically appropriate.

However adequate staff training and presence in an environment that is not crowded or boring may reduce seclusion rates.

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

A coordinated, nationally endorsed stigma reducing campaign needs to be implemented as a feature of the National Mental Health Strategy. The campaign strategies should include:

- Media promotion
- School education programs
- Training of mental health professionals in relation to iatrogenic stigma (ie. stigma arising from the attitudes and behaviors of healthcare workers)

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.

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

The manner in which we entice a more research oriented workforce has not been fully explored. Inculcating this philosophy into the undergraduate population could attract more staff with research leanings.

Options are being considered by Latrobe University in Melbourne to consider offering a 4-year undergraduate degree so students can graduate with an honors degree.

This allows direct entry into both Masters and Doctoral programs. To date there is no financial incentive for students to graduate with an honours degree. The decision students will need to make is whether to attend another University and graduate with a 3 year degree, and be in an earning capacity at the end of that period, or persist for another 12 months.

This demonstrates not only the capacity for innovative thinking, but also the need for it.

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

Inflexible data collection processes and excessive paper work requirements continually overburden clinicians.

Experienced mental health clinicians are tied up for hours a week inputting data rather than doing mental health assessments in the community, including emergency departments.

A data collection system needs to be implemented that:

- provides real time statewide bed status.
- enhances and facilitates timely communication;
- provides for standardisation and uniformity;
- provides real time clinical data at numerous points across a mental health network, including the level of complexity of presentations;
- the capacity for mental health clinicians to access detailed and up to date clinical information, including management plans, risk factors, current treatment, current case management, strategies for management of crises;

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

The treatment of mental illness the therapeutic use of the self as the most significant intervention. Accordingly, it is the union's view that it is always preferable to deliver mental health care face to face. In noting this, the union is realistic to understand that in remote areas in particular this may not always be possible and that other means, such as technology, may be useful interim substitutes.

The union cautions that such substitutes should not be the norm and every effort should be made to ensure recruitment and presence of appropriately qualified, skilled and trained mental heath professions to all areas.

Having said that the use of e-technology and other technological methods are useful record and data collection and keeping – see in particular comments under term of reference O.

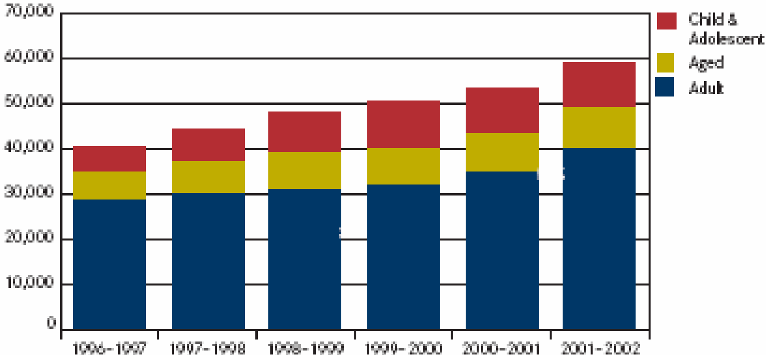
SUPPLEMENTARY DETAILS REGARDING VICTORIA AND TASMANIA

Victoria

Victoria was once arguably a leader amongst the States in progressing mental health reform. The stand-alone psychiatric hospitals have been closed and the basis for a community based clinical and psychosocial service system established.

However any claim to excellence has been compromised by the challenges of the post deinstitutionalisation era

- Demand for services is at an all time high and exponentially growing. Growth in demand has averaged 8% per annum over the period 1996-2002. In the final year it was measured, (and publicly available) this growth had reached 10.6%. (Metropolitan Health Strategy DHS 2003, Mental Health Three Year Outlook 2003/04 to 2006/07 DHS 2003).



- Further examination of these figures shows that in the critical adult age group, the 16-64 year old group, growth in the final year was 14.6%. The Department of Human Services predicts this rise in demand will be sustained.
- Currently the mental health system is not coping with its current client load. "A high proportion of long-term, high need, consumers were using the community clinical services and home based outreach and day program services, thus limiting the capacity of these services to take on new clients" (Mental Health Three Year Outlook 2003/04 to 2006/07 DHS 2003).
- There is a chronic shortage of beds both acute and disability support – this is confirmed by the Auditor General (Mental Health Services for People in Crisis October 2002), Community Visitors (Annual Reports to Parliament) and other Government reports.
- Hospitals are regularly forced to admit mental health patients to accident and emergency departments for days at a time, as no acute beds are available.
- In Victorian Emergency Departments people with a mental health diagnosis wait longer on trolleys than people with any other diagnosis (Public Statements by Minister of Health Bronwyn Pike MP).
- Homelessness is now an acceptable outcome after an episode of care in an acute psychiatric unit. HSU members, especially social workers are required by hospitals to organise this type of discharge in spite of the questionable nature of such discharge planning. The Salvation Army's Flagstaff hostel, The Society of St. Vincent DePaul's Ozanam House and Hanover Southbank are now direct discharge destinations.
- People who may never have accessed a homeless service are now introduced to homelessness in order to free up beds for those seeking to enter the mental health system.

Tasmania

The Tasmanian State Government recently announced a $47 million over 4 year's investment into mental health services across the state. These initiatives included:

- Additional care packages for clients to live in the community
- A 12 bed high support community facility in Launceston

- A 12 bed cluster house in the North West of the State
- A 12 bed cluster house in the South of the State
- 26 FTE clinical positions in Child and Adolescent Health Services
- 16 FTE clinical positions in Adult Mental Health Services
- 6 FTE clinical positions to work with elderly mental health clients
- $3.78 million to support safety improvements, assist with the implementation of the Mental Health Act and to develop a mother and baby service
- $3.74 M to establish recovery programs
- $4.52 M to upgrade facilities

What is missing in this announcement is further funding to support tertiary inpatient programs.

One of the major issues advised to the union by members is an increase in the level of inappropriate placements in inpatient facilities. Currently all facilities work at maximum occupancy and little flexibility exists to ensure that patients (when they present) can be placed in an appropriate facility.

Up until recently, the state had a significant shortage of appropriate accommodation options for mental health clients. This should in part be resolved when the new funding comes online. However there are concerns that this may not be sufficient.

As with the rest of Australia there are severe shortages in nursing staff. Major concerns exist with regard to the capacity of the Government to attract sufficient numbers of staff into the state to fill the positions recently announced in the Mental Health Funding Package.

There are not sufficient enough staff opting to specialise in mental health and there is the lack of real articulation between the VET sector and the tertiary sector.

Appendix A – Witness Statements

1. Ms Angela Gallagher

1. My name is Angela Gallagher and I am a Registered Psychiatric Nurse working in the CATT team at Eastern Health in Melbourne.

2. I have been a nurse since 1984 and in psychiatric nursing since 1986 which gives me almost 20 years experience in the area.

3. My primary role is to do the initial assessment on people in the community to determine whether they have a mental illness and whether they need treatment in hospital or in the community.

4. The work has become more difficult and stressful in the last one to two years due to the high demand and the shortage of appropriate services.

5. We also often have difficulties with staff numbers in the CATT team. Our manager is very good in bringing people but when there is a shortfall inexperienced staff are called in and there is an increase in overtime. It also means less time is available to spend with clients.

6. It can also be difficult to find a doctor available to visit a client. People are always shocked when you tell them it may be 24 to 48 hours before a doctor can visit.

7. It is much more difficult to find a bed in a hospital than it used to be. It is a constant and daily occurrence that the search for a bed is undertaken. It can take hours and you are ringing all over the state.

8. Inevitably there are no beds in the state. I have had to send people as far as Bendigo to get them into a hospital bed. I am reluctant to send them any further because it is hard on them because don’t have the support they need close by.

9. It is a source of stress and anxiety for staff that it is so hard to find a bed. It is also a source of much stress for families. Particularly if their son or daughter has just had their first acute episode it is hard enough to deal with that let alone the fact that it is very hard to get the appropriate services.

10. A couple of years ago we would have been really reluctant to put someone who needs a bed into a hospital emergency department. But now quite frequently you don't have a choice. Often the ED staff are not happy about it either because they know there is not the beds available to move the client to. It can lead to tensions between staff in the ED and the psych wards. Those difficulties in getting treatment impact on care. People get disillusioned and downhearted.

11. Even if a client doesn't need hospital treatment it is difficult to get them properly treated. Case managers at mental health clinics in the area are already so overwhelmed and complain constantly of high workloads.

12. Even clients who are referred to clinics will only have a certain amount of treatment because the workloads are so high there is a lot of pressure on the clinics to discharge people. Within a few weeks or months of being discharged they may have an acute episode and things start again.

13. It is also extremely difficult to get them counselling. People who need treatment are often not well off financially so getting them in to see a private psychologist may not be an option. We try to go to the non-government organisations.

14. Over the last three to four years the role of CATT staff has been broadened. We know deal with people outside the boundaries of mental illness including suicide, self-harm, drug and alcohol, marital break-ups, adolescent and gambling cases. That means increased demand but the beds remained the same.

15. Our training in some of these areas has been good and the union has certainly helped in this area in getting nurse educators back into hospitals.

16. But I have always felt our training for dealing with adolescents and drug and alcohol clients is very limited.

2. Dr Anthony Llewellyn

1. My name is Dr Anthony Llewellyn. I am 33 years old and reside in Newcastle, New South Wales. I am a recent Fellow of the Royal Australian and New Zealand College of Psychiatrists.

2. I work as both a Medical Manager and Staff Specialist at the James Fletcher Hospital as part of the Hunter New England Mental Health Service. I have had over six years full time experience in the public mental health system.

3. My comments are a reflection of both my experience as a psychiatry trainee as well as somebody with an interest in health policy and organisation. I have specifically studied extensive literature into the issues around psychiatry recruitment and training. I have also been a member of the Health Services Union for 8 years and a Councillor of the HSU for 7 years.

4. The College of Psychiatrists is consistently failing to match targets of 120 new trainees per year and rates of new College Fellows are insufficient to sustain, let alone expand mental health services. This problem is worsened by the shortage of General Practitioners, who generally "take up the slack" when psychiatrists are not available and are particularly essential for the work of private psychiatrists and mental health teams in monitoring and continuing care of patients.

5. One problem with the College has been the unending reviews of training and curriculum, which have led to a system, which has been inconsistent and unpredictable for trainees and thereby serving as a disincentive to want to undertake training in the psychiatry specialty.

6. In many senses over the last few years the trainees appear to have been more organised than the College itself, viz the Trainee website in comparison to the College website.

7. The College is an ever-expanding monolith, which makes its decisions through a vast number of committees. It appears to have high turnovers of support staff. Its fees have increased by almost double in the last few years and the number of staff employed have also increased; yet the quality does not appear to have improved.

8. The training experience has also narrowed. Consultants who have trained in other eras consistently talk about how their training experiences were far less pressured and that the breadth of experience was much wider. Many trainees are now forced to work on crowded, busy acute adult inpatient units, where the disorders are generally restricted to three or four diagnoses. The patients are chronic and almost impossible to treat and the focus is mainly on the biological therapies.

9. There is a severe lack of exposure to higher prevalence disorders and patients who actually get better, as well as psychosocial treatments and general practice liaison. All of these are important to passing the College examinations as well as being the meat of private and consultant psychiatry.

10. The experience of trainees after-hours is of particular concern. Frequency of being on overtime or on-call can be quite high in areas, leading to fatigue and burnout. Patients seen after-hours are often in crisis, are feeling vulnerable, transfer various emotions on to those people who attempt to help them and are often seeking help and assistance as their normal supports are not available or do not exist. Alternatively, they can often be intoxicated, threatening and abusive.

11. Trainees are given skills to deal with these difficult emotional circumstances, but everyone has their limit. This is particularly so when

your main goal is to establish a short-term management plan which particularly addresses the issue of safety. Discharging patients in such circumstances can be risky and play on the mind. Unfortunately, many trainees are placed in such a situation where they are forced to gamble on risk because there simply isn't a bed available and there is no longer a 24-hour team to follow-up with.

12. In Sydney it is not uncommon that there is no bed available in the entire city some nights. Patients are sometimes transferred to Newcastle or Wollongong if this occurs. Registrars in Sydney frequently spend their nights on driving from Hospital ED to Hospital ED copping abuse from ED staff angry with mental health patients clogging up their department looking for the last remaining bed available in Sydney.

13. Some units are known to deliberately fabricate their bed and leave status in order to hold a spot in order to cope with projected future admissions. There is actually little incentive to discharge patients as the ones present on the ward are inevitably easier to deal with than the ones who come in to fill their spot.

14. Most Psychiatrists, myself included, have had patients who have suicided. This is not easy to deal with. One of the persons who I commenced training with had two people suicide and one patient remove their eyes in the first six months of training. Suffice to say he gave up training after his first year.

15. Suicide and homicide are almost completely unpredictable. Essentially there is no medication, treatment, tool or risk factor, which, if used or addressed, has been shown to accurately improve outcomes for either suicide or homicide. Patients even commit suicide in hospital under close observation.

3. Paul Healey

1. My name is Paul Healey and I am a Registered Psychiatric Nurse. I work as a senior staff member in a Royal Children's Hospital inpatient unit for children and adolescents. The unit has 12 beds and is located on the Western Hospital site in Melbourne.

2. We cater for kids aged between 12 and 18. I have worked on the unit for 12 years and have been a nurse for 20 years.

3. Over the period I have worked on the unit the number of admissions has grown from 80 to 300 a year. Demand continues to increase rapidly. We find the problems kids are coming in with are getting more complex.

4. Drugs are more of an issue now than they ever have been. When I first started you would have a few kids smoking dope, but now they are using a whole heap of drugs. We see a lot of cases of chroming and overdoses. Drugs that kids are overdosing on can be illegal or legal such as Panadol.

5. Over the year our occupancy rate is about 50 per cent because we have the shortest length of stay of any of the child and adolescent inpatient units in Melbourne. At the moment we are full and flat out. Usually we get busier as the year goes on. The fact we are so busy now shows the increasing demand.

6. The biggest problem we see is the lack of support for young people in the community. There are major issues trying to get follow up services, family therapy and accommodation. There is no day program for the kids so they have to go back to school if they fit in or not.

7. It can take a week just to get an appointment for family therapy and this delay puts a lot of pressure on families.

8. Once the kids are in our unit we are responsible for them, so it is up to us to find them accommodation if they need it. Supported-accommodation is non-existent. We spend hours with kids trying to find them somewhere worthwhile. Until we find them somewhere they stay in the unit because we are not going to put them out on the street. That means they remain in a bed and that slows the system's throughput.

9. Over the years it has been hard to find staff to work in the unit. It is really difficult to find experienced staff because they are not out there. What we have found to be successful is recruiting lots of graduate and postgraduate students and then giving them the specialised training they need in the unit.

10. There is a need to further develop community based support teams to enable a smoother transition from inpatient care, but more importantly there needs to be an improved system for supporting the kids and their families in the community. The greater support for families in the community is necessary to maintain the family unit and to foster normal child and adolescent development, thus often preventing the onset of mental health issues.

4. Bill Deegan

1. My name is Bill Deegan and I work as a registered psychiatric nurse Level 3 shift leader at the Austin Health Repatriation Hospital in Melbourne.

2. I work in the acute inpatient unit at the hospital since 2003 and have thirty years experience in psych nursing.

3. In my time in the job the biggest changes have been the increasing shortages of available beds in the unit and also the change in the patients. They are younger these days and more problematic.

4. We find an increasing number have drug or alcohol problems as well as mental illnesses. That presents a lot of problems. Work has become more dangerous.

5. Three times recently we have had to call the police into a unit to deal with a patient who was locked in seclusion. There is more stress and you take a lot of your work home with you. I am 54 now and getting too old to wrestle.

6. The shortage of beds often becomes a problem on weekends. We are full most of the time but weekends are notorious. There is huge pressure from other areas.

7. We very rarely go over our numbers but there are always people calling looking for beds and it can be stressful if people think you are hiding beds or not telling them the truth.

8. The Austin Hospital receives many out of area patients from services located at Maroondah, Box Hill and Northern.

9. Recently one Austin Health patient was sent to the La Trobe Valley hospital from the Austin Emergency Department for two days and then brought back to

the Austin psych unit. Around the same time I received a call from Mildura Hospital looking for a high-dependency bed.

10. We have two units with beds for mothers and babies and eating and mood disorder patients as well as veterans and sometimes we have to put people up there.

11. It would be better if there was a centrally co-ordinated system for the allocation and notification of beds. At the moment it is left to the areas but there are problems with that system, particularly if people do not update their data regularly enough.

12. Sometimes patients are discharged too early because there is so much pressure to free up beds.

13. Certainly finding extended care beds is a problem. We have three for the area but at the moment they are effectively blocked because the people in them will be there until they die.

14. Staff shortages can be a problem, particularly around school holidays. Sometimes when a lot of staff are sick it can be extremely difficult to find replacements. There are times when there is a lot of overtime. The vacancies are filled by agency staff who often may be there for one day and there is more pressure on other staff to ensure they are doing their correct job and its safe.

15. It is hard to attract young nurses into psych units. Under the university training system a lot of kids seem to be directed towards general nursing and they don't get the experience or the training in psych. Cadetships outside the university academic year may be one way to develop and attract nurses into psych.
16. I wouldn't say the staff training was ideal. It seems to be more about covering what is required for health and safety rather than providing us with the skills that we need.

5. Anthony Collier

1. My name is Anthony Collier and I am employed as a Senior Social Worker within the CAMHS sector in W.A.

2. The CAMHS population makes up significantly more of the WA population than the proportion of the mental health budget that is allocated for providing services for this population. This, combined with the increasing recognition of mental health issues for the 0-18 yrs age group results in many CAMHS clinics having waitlists of up to 8 months and longer in some areas. Given that the mental health issues of CAMHS clients can be exacerbated by delays in treatment, waiting for treatment does not improve the prognosis of these children and adolescents.

3. Another issue affecting CAMHS is the lack of emergency and after hours service provision. Princess Margaret Hospital offers the only specialist CAMHS emergency service available after hours and this is only available for clients under sixteen years. Clients living in rural and remote areas do not have access to out of hours specialist services. The Psychiatric Emergency Service (PET) does provide adhoc services during after hours times. However the staff members of the PET are not specialist CAMHS trained. Many children and adolescents may present with severe behavioural issues, which mask underlying psychiatric issues which are nor always recognised at times of crisis.. PET consultation is limited to phone access for clients in rural and remote areas.

4. There is a lack of permanent Consultant Psychiatrist services to several CAMHS clinics in WA. Although steps have been taken in some areas this situation has yet to be fully resolved. In at least two instances this lack of service is evident in geographical areas of varied and low social-economic status. This compels parents to either pay for private services, which they may not be able to afford or forgo a psychiatric assessment for their children.

5. The absence of formal CAMHS training means that there is difficulty in attracting skilled staff. This is particularly evident in rural and remote areas where there are a number of vacant positions for CAMHS staff resulting in further limitations for CAMHS in rural and remote areas.

6. There is only one day treatment program for CAMHS clients in WA (this limited to inpatients or former inpatients in transition) located at the Bentley Adolescent Unit in Bentley. Bentley is located in the metro area and is distant geographically for rural and remote clients and also up to 50 kms away for CAMHS clients of some metro clinics. These issues of distance make access for families more difficult in certain geographical areas.

7. There are limited services for children over five from the Child Development Services. (CDS) This has a specific impact for older children who present to CAMHS with issues of a developmental nature that are interrelated to mental health issues. Lack of access to speech and occupational health services in many CAMHS clinics effects the treatment provided and the prognosis of CAMHS clients. This situation is exacerbated in rural and remote areas where shortages of both CDS and GPs (as frequent referral agents) result in further access restrictions to developmental services for children under five in these areas. The lack of bulk billing GPs in many rural remote areas makes access to primary mental health services and referral to CAMHS even more difficult for clients in rural and remote areas.

8. There is a lack of a comprehensive program for Indigenous CAMHS clients. This is a tragic state of affairs as the morbidity rate for mental health issues is significantly greater that of the non-indigenous population of WA as expressed in the recent Institute of Child Health Research report.

9. There is no dedicated planning mechanism for CAMHS in WA despite this being recommended in several reports over many years.

10. There are no early intervention or coordinated preventative programs available. This combined with CAMHS having limited resources means that clients often

reach CAMHS services in a state of crisis or with chronic mental health issues which are more entrenched and difficult to treat.

11. There is a recognised increasing complexity of CAMHS cases with families presenting with domestic violence, substance use and as the children of parents with mental illness (COPMI). While the COPMI initiatives in WA have recognised this issue and made some positive steps in offering integrated services for families it remains a frequent and serious issue. The introduction of Multi-Systemic Therapy in Western Australia is certainly awaited with optimism but the service will be limited in the number of clients it can work with and also will have strict geographical limitations. Once more rural and remote areas have yet to receive plans for such services.

6. Gail White

1. My name is Gail White and I am a Senior Social Worker in Adult Mental Health at Bentley Hospital in Western Australia.

2. We have a 54-bed in-patient unit and a community out-patient clinic, catering for people 18 and over with a treatable mental illness.

3. I have worked here since 1997 and our client base has grown substantially since then, while our level of staffing in my area has remained unchanged.

4. When I began in this position, our in-patient unit almost always had some unoccupied beds, but for the past five years the unit has almost always been full, with patients routinely unable to be admitted here and sent to out-of-area hospitals. This results in considerable hardship for themselves and their families, and no doubt the lack of support can lengthen their stay.

5. Their recovery is also enhanced if they are in their local area with access to the government and non-government services which they will be using after discharge.

6. Also, the care of the mentally ill is greatly enhanced if they are being treated by people who know them well, and if they are hospitalised out-of-area, this does not happen.

7. Understaffing means that our care is spread thinner. Consumers are given less time to talk, fewer appointments and fewer, if any, home visits. As Social Workers we do a lot of work liaising with other agencies and advocating on behalf of our consumers. Having insufficient staff, these services are curtailed and often we can only do the most important but basic linking.

8. The overall effect is that our interventions are less thorough, and this no doubt results in increased numbers of contacts and admissions in the long term.

9. It also gives rise to dissatisfaction on the part of employees, who know that if they had more time, they could do the job they were trained to do. This sets up conflict with their professional ethics and creates a problem with staff retention, which has been a big problem in Western Australia in recent years.

10. We would all wish to implement the National Mental Health Standards in spirit and in fact, but in many respects this is impossible. For example, it is required that we conduct a team review of each client every 3 months. In our case, this would mean 50 team reviews per week, and this is plainly impossible because of the time involved.

11. Social Workers, and other health professional, on entering the mental health field, need quite extensive training in this specialist field over and above their basic degree, if they are to do justice to their consumers. While a few good courses are available, there are not enough. Those that are available are offered in the private sector and too expensive for the average staff member to attend as many as they should. Pitifully few in-service courses are offered by many of the hospitals because their budgets for staff development are inadequate.

12. Continuing professional education is also important to keep staff up-to-date with current developments in the field and to maintain their enthusiasm for their jobs.

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