Victorian Mental Illness Awareness Council Inc.

Submission

To

Human Rights and Equal Opportunity Commission & Mental Health Council of Australia

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Preamble:

The Victorian Mental Illness Awareness Council (VMIAC) is the peak consumer organisation for people with a mental illness and emotional problems in Victoria.

The State and Commonwealth governments provide funding for the organisation. The services provided include:

individual, group and systemic advocacy;
mutual support and self-help;
consumer, service provider and community education.

Currently, the VMIAC staff undertake monthly visits to most inpatient facilities to talk to people about their rights and attend to any advocacy issues they may have.

Additionally, the VMIAC have 82 consumer groups located across the State and a VMIAC staff member attends these groups on a monthly basis and undertakes group advocacy as needed. Given these activities, the VMIAC is well placed to provide information about mental health services in Victoria.

Reviews:

In 2000 a statewide review occurred in Victoria of acute inpatient facilities and statewide specialist services. Anecdotal conversations at the time suggested that all stakeholders were of the same opinion. Funding was inadequate and the impact of the mental health care system on patients was detrimental.

The results of the review were never made public and while the State government has attempted to improve the plight of consumers, services remain negligently inadequate.

The Victorian Auditor General's office also conducted a review of mental health services in 2002. While there was some disagreement with the Department of Human Services about the accuracy of some of the data included in the report, the report nonetheless was quite critical of services.

Mental Health Structure:

In Victoria the structure for providing public mental health clinical and non-clinical mental health services is as follows:

Clinical:

Crisis Assessment and Treatment teams;
Inpatient units;
Step up, step down facilities (undergoing pilot trials);
Mobile Treatment and Support Teams;
Community Care Units;
Secure Extended Care Units;
Continuing Care Teams;
Case Management;
Shared Care services;
Primary Mental Health & Early Intervention services;
Statewide Forensic inpatient and out-patient services;
Statewide Eating Disorders units;
Statewide Mother and Baby units.

Non-Clinical: Psychiatric Disability Support Services that include:

Home Based Outreach Support services;
Rehabilitation and Support services;
Mutual Support and Self Help;
Supported accommodation;
Drop-in services.

Legal & Advocacy: Under the Mental Health Act people with a mental illness are entitled to have a lawyer represent them. Consumers are also entitled to have an advocate. Provision also exists for the Community Visitor program that works out of the Office of the Public Advocate (OPA). The Guardianship and Administration Act also provides for the appointment of advocates. Due to the high rate of guardianship appointments, which is an issue in itself, little advocacy is carried out by OPA.

In Victoria there are three main advocacy services that people with a mental illness use; that is, Legal Aid, the Mental Health Legal Service and the VMIAC. While there are other advocacy and legal services in the State, their clientele tend to be those with intellectual, physical or sensory disabilities.

Introduction: It is the view of the Victorian Mental Illness Awareness Council Inc. (VMIAC) that, even though very positive changes have occurred through mainstreaming, organisational structural changes, policy development, etc., these changes have had little to no impact on the responsiveness and respectfulness of service delivery to consumers generally. For this reason, our comments will include matters regularly identified by consumers as imperative if services are ever to be delivered in a manner that they wish and deserve.

Politics: It is unfortunate, but a culture exists which places the protection of government, Ministers, bureaucrats, organisations, managements, clinicians, and service providers above the protection of patients, in particular those with a mental illness.

Where governments and Ministers are concerned, the driving force for decision making is gaining votes and staying in power. When things go wrong or standards are not being met and it is impossible to deny the problems, they look for someone else to blame, and more often than not this is the bureaucracy. Government gives little consideration to the fact that they are accountable for creating a culture that no longer allows for public servants or anyone else to provide advice without fear or favour. Those of us who are not restricted, or refuse to be restricted by this culture of immaturity, are more often than not labelled as unrepresentative; we exaggerate or are ill informed, etc., etc. We are seen as people who simply cannot be trusted. The fact that little to no public protest has been heard by the "leaders" in the mental health care system, whose major responsibility should be to ensure service delivery is accessible and holistic, is a good indication of how bad the culture is. When the VMIAC Director asked a senior psychiatrist from the Australia & New Zealand College of Psychiatry why they did not speak out, she was told that if they were critical of the government, the government would not speak to them.

Demonstrating positive leadership and doing what is ethically right for the people of the State or country is virtually non-existent unless there is a vote in it. Human rights abuses are common, in particular for those with a mental illness, and governments and Ministers are doing nothing to stop it. At a Federal level, we are ashamed to say that it is done to gain votes. Detaining men, women and children who clearly have mental illnesses due to untold trauma is a good example of this. Notwithstanding this, the VMIAC recently advocated for a man with a diagnosis of schizophrenia who has lived in Australia for over 20 years. He was on a disability pension, had an Office of Housing flat and his funds were being managed by State Trustees. He was picked up by the police without warning and taken to the Maribyrnong Detention Centre. The client was not allowed to bring toiletries or a change of clothing with him. The reason for his detention was that he had failed to complete a visa extension application 22 years ago. No consideration was given to the client's level of disability, capacity, or his illness. While our client is now living in the community, it took intensive "stamping of feet" at all levels of government to achieve this. A legal battle is now going on to keep him in Australia. It should go without saying that much unnecessary stress, confusion and pain has been caused to this man who is unable to defend himself.

Independent Agencies:

The VMIAC has had concerns about the lack of independence of so-called independent agencies for some years.

While we have no recent examples of cover-ups, this does not mean that inappropriate activities to protect government or Ministers or the head of an independent agency are not still going on, but rather we just haven't heard of any.

By way of example, some years ago a couple of Community Visitors working in separate services told VMIAC staff they were resigning from the Office of the Public Advocate (OPA) because their annual reports were "watered down" to such an extent that they bore no relationship to the submitted report.

In one instance a case was not pursued because the independent agency had put in a submission to government for an increase in funds and it was felt that the money would not be provided if the case continued.

The Victorian Mental Health Act provides for the Office of the Chief Psychiatrist. The Act gives clear directions regarding the Office of the Chief Psychiatrist and its responsibilities for standards of patient care. However, it is not uncommon to hear the remark, "We are here to protect the Minister." The Director of VMIAC heard this comment first while working in the Office some years ago, and has since heard it repeated. Anecdotal examples include a past Chief Psychiatrist and staff who engaged in lying, and whistleblowing on the whistleblowers after giving them a commitment to keep their names confidential from their management. In some instances, evidence in medical files that demonstrates neglectful and abusive care and treatment has been ignored. While many of these people no longer work in the Office, it should never be the case that addressing standards of care is driven by political considerations rather than established standards of practice. A recent example perhaps best describes how politics influences decision making rather than standards of treatment and care. A forensic patient put in an application to the Forensic Leave Panel for unescorted leave. His treating team, the Panel judge, psychiatrist and community member supported the leave application. The member from the Office of Chief Psychiatrist, however, did not support the leave. The reason given: "What if you were out on leave and someone recognised you and phoned the Herald Sun."

What does it say about the independence of the Office of the Chief Psychiatrist when it allows the Herald Sun to influence the Office's duty to uphold standards of treatment, care and rehabilitation?

In summary, consumers and advocacy organisations should not have to rely on the personal ethics of the individual Chief Psychiatrist and his or her staff when it comes to standards of practice or complaints about same.

Additionally, anecdotal evidence exists that much pressure was placed on the Auditor General's Office to "water down" the recent report into mental health.

Recommendations:

(1) **While it is recognised that there is a close working relationship between the Mental Health Branch and the Office of the Chief Psychiatrist, that consideration be given to altering the Mental Health Act to ensure the Office of complete independence; and further, that the Chief Psychiatrist be required to submit an annual report to Parliament regarding standards of patient care.**

Rationale: ***Ethically, the maintenance of adequate funding for health services, and in particular the maintenance of accepted standards of practice, should be the responsibility of all politicians and not just those in power. In recent times, political interference at a bureaucratic level for "self" protection has become the norm, irrespective of which party is in power. It should cease. Cease because it is preventing people from doing right by their patients, it is reinforcing the view that the patient is the least important person in the system, and it has such negative consequences for patients generally.***

(2) **That staff of all independent agencies be required to undergo ongoing education about mental illness, stigma-related activities and defensive reasoning practices.**

Rationale: ***It should never be assumed that people appointed to work in independent government agencies are exempt from prejudicial attitudes towards those with a mental illness, and ongoing ethical reflection should be a requirement of continued appointment.***

(3) **That an independent Department of Ethics be established for the purpose of providing advice, education and support to independent and other non-government agencies around ethical dilemmas and unethical practices; and further, that this department be required to provide a report to Parliament annually.**

Rationale: ***Providing for an "ethical watchdog" for all levels of government and non-government agencies should assist in reducing cynicism and enhancing ethical reflections on practice and further, put natural justice back into the health and community service industry. Put simply, we desperately need an organisation that assists independent agencies and others to stay honest.***

Culture: If the health care system is to ever deliver a service that is responsive and respectful to those who use the service, then the culture needs to be changed not only for the benefit of consumers, but for health professionals as well.

Currently the system does not reward advocates, health professionals or other service providers who make a stand over patient care or consumer issues when practice has been inappropriate. Rather, the culture is one of defensive reasoning, for example, blaming. The blame is often squarely laid at the consumer's mental illness, resulting in the issues of concern being lost to this defensiveness. This occurs even though the practice may be quite disrespectful, inhumane and outside policy guidelines. Those advocates, health professionals and other service providers who refuse to go along with and justify inappropriate practice more often than not end up in the "shoot the messenger" scenario. That is, all effort is made to discredit the messenger. As a result, we have a system of health and support service delivery where fear of jeopardising your career and relationships with work colleagues overrides attention to disrespectful standards and errors of practice. In other words, organisational defensiveness pervades the mental health service system to a point where the issues important to the consumer are never really heard or actioned upon and accountability is nothing more than a theoretical exercise. Moreover, if the culture is not addressed, having a respectful patient and/or consumer-orientated service will never be realised.

For reasons beyond our understanding, it would seem that both in the clinical and non-clinical sector we have lost sight of the basics. At a minimum, the basics should be that we do no harm, ensure the protection of our patients or clients, and fight for the right of everyone to receive natural justice. Unfortunately, we no longer seem to support or have an interest in the basics.

Recommendations: **While it is recognised that the Department of Human Services has funded the provision of supervision for clinical staff, and the appointment of senior nurses to assist in a change of culture, these provisions have had little**

positive impact on the culture. It is therefore recommended that all Statements of Priority (service agreements) between the Department of Human Services and the local mental health service contain a requirement to proactively address the service culture; and further, that each service be required to submit an assessment of the current culture, a 5-year plan for improving the culture, and a progress report to the DHS Mental Health Branch on an annual basis.

That all management and staff be required to undergo education on change management, defensive reasoning and complaints handling practices as part of the cultural change processes.

Rationale:

Changing the culture of the mental health care system can only be achieved through the leadership and activities of management at a local level. For positive change to occur activities need to be planned, persistent, consistent, prescriptive and inclusive of all stakeholders at all levels. Given that there has been ample time for managements to take up the issue and they have failed to do so, it is now time to provide some prescriptive direction.

For the past 15 years, the Director of VMIAC has observed the management of change in the mental health system in Victoria. As a person who has studied the subject, it has been of particular interest to watch the change process, knowing that many of the processes have defied the theory and practice of effecting positive change. Clearly some education is required if change for the benefit of all stakeholders is to be realised.

Clinical Issues

Attitudes:

It has been the experience of the VMIAC that, more often than not, if you ask consumers if they could wave a magic wand and change something about the mental health system what would they change, the attitude of health professionals is the most frequent answer, followed by access to services.

Contrary to all the policies that have been introduced including Individual Service Plans, case management, consumer participation, etc., the medical model approach to care and treatment pervades the mental health system like a disease. It occurs to such an extent that many individual consumers describe themselves, including introducing themselves, as a mental illness. The consumer's personhood becomes completely lost to the mental illness and it is the mental health system and the way consumers are treated by clinical staff that is largely responsible for this. "Normal" everyday grief, distress and anger are attached to the illness, precluding the person from experiencing the empathy that those who don't have a mental illness expect and receive as a normal everyday occurrence. This situation is so bad that many consumers believe that the attitudes of health professionals, in particular psychiatrists, are far worse than the attitudes displayed by the general community.

While it is important to acknowledge that not all clinicians see consumers only in terms of their mental illness, they are so few in number they stick out like lighted beacons. In making any change in attitude, it needs to be understood that we all have flaws in our nature, and habits of practice, namely:

> ***If we see something often enough we cease to see it. If we do something often enough we do it without thinking. If we think something often enough we think it without challenge. If we hear something often enough we will hear it without question. When dealing with people, we are only dismissive or abusive of those in a less powerful position than we are. If abuse is not happening to ourself or someone we care about, more often than not we do nothing about it, or discredit those that do.***

If things are to ever change, then persistent and consistent consideration needs to be given to these issues.

Recommendation: **As per recommendation on cultural change.**

Staff Issues:
Stress:

The VMIAC currently visits most inpatient units throughout Victoria on a monthly basis to talk to patients about their rights. It has been of concern to us for some time that the stress levels of the staff are very high. While supervision and debriefing are now provided for clinical nurses, there still appears to be a lack of recognition of the impact looking after people with a mental illness can have on those who deliver the service. Notwithstanding this initiative, we have not observed any improvement in practice. In some instances, there also does not appear to be any recognition of the need for ongoing support. It is our perception that managements including "clinical managers" in the general health care system lack an understanding of the "emotional busy-ness" of psychiatry and the impact this can have on the clinical staff's emotional tiredness generally. If staff are ever to regularly reflect on their practice, it is our view that there needs to be a recognition that caring for and treating people with a mental illness can be emotionally draining; and as such, measures need to be put in place which recognises this. Put simply, you cannot expect staff to be responsive and respectful to patient needs when the managers of staff are not respectful and responsive to the needs of their staff.

Notwithstanding the above, a change in culture and attitudes cannot occur without active input from management at a local level. It may be initiated by the Department of Human Services, but unless the local managements take it up as an issue it simply will never occur.

Experience of Staff: It is our view that there appears to be a shortage of experienced staff, which again not only impacts on the stress levels of staff, but on patients as well. It is not uncommon for patients to express concern about the stress levels of staff. We believe patients have enough to worry about without having to be concerned about staff. On some occasions when we have mentioned these concerns to individual managers, the response is often that the "staff put patients up to this." This sort of defensive reasoning does nothing to solve the problem – it just facilitates its continuance. It also demonstrates a lack of concern about staff and/or ignorance about the problems within their organisation and their responsibility to take care of their staff and address issues of concern.

Recommendations: **See recommendations made under the heading Psychiatrists and Nursing.**

Psychiatrists & Nurses: The VMIAC would stress that there are some very good psychiatrists and nurses working in the mental health system. The behaviours they reflect include the following:

They use a humanistic approach in delivering their clinical practice. In other words, they display empathy; they talk *with* the patient as opposed *to* them. They are responsive to the patient's concerns. They are respectful and do not see everything in terms of a mental illness. They are open and honest with patients and never dismissive. Unfortunately, patient feedback and our own observations indicate that these attitudes do not pervade the system, but rather are rare.

It needs to be stressed that it is a totally incorrect assumption to say that because one health professional treats patients with respect their colleagues do the same. It is also incorrect to assume that because a colleague treats another colleague with respect, that respect is also used in interactions with patients. When concerns about a psychiatrist's attitude are raised with management the response is usually – "I think they are nice people." Again this is a defensive reasoning response. One is not making comment about the personhood of the person, but rather their practice as a health professional.

The behaviours of psychiatrists and nurses that generally pervade the mental health system include:

> Seeing everything that is expressed by the patient as part of the person's mental illness. This occurs to such an extent that the individual patient is precluded from having normal everyday human responses, responses that we would all have under the same circumstances.

By way of example, a client has given us permission to use his case as an illustration of poor practice.

This client is a 55 year old married man with 2 daughters. He is a Muslim who emigrated from Iran some 20 years ago, having been a political prisoner who endured torture.

The above was noted in his medical file.

He was voluntarily admitted to a psychiatric inpatient facility for treatment of his depression and to obtain assistance with anger management following frequent episodes of discriminatory remarks made to him in his work setting. He was a computer programmer.

The medical file contains no evidence that this man received any treatment other than medication, and he spent his days engaged in "occupational therapy" activities. This is despite a care plan that states he was to be provided with "various therapies" to assist him with his anger management.

Our client decided that hospitalisation was not going to be helpful. He expressed a number of concerns to his doctor and contact nurse and indicated that he was going to leave. There is no evidence in the file of any attempt to resolve my client's concerns. After he had packed his things he went to the ward office to inform the staff that he was now leaving, and then proceeded to leave. The client was grabbed by a number of nurses, held down and injected, and he woke up in a seclusion room with nothing but his underpants on. Seclusion was ceased at 7pm. Mental health documentation indicates that the client was made involuntary and secluded because he was an absconding risk, refusing to take medications, totally insightless, had impaired judgement, elevated in mood, etc. It was also noted that he attempted to kick the unit manager (left out of the notes that the physical tussle occurred during the staff's attempt to seclude him. The client was discharged the following morning with no follow-up arrangements because he had "no psychiatric symptoms, compliant with medications/no aggressive impulses."

The result of our client's first hospitalisation is that he has no faith in the public mental health system, he is having nightmares and flashbacks about his time as a political prisoner and his seclusion experience, and he feels more depressed than when first admitted. As a Muslim he feels humiliated in particular about being de-clothed.

The above example of emotional indifference to patients is not an uncommon one. When things like this happen to a patient, the staff's defensive reasoning skills take over and the normal everyday human response of the patient gets lost with such arguments as the person is insightless, their concerns, anger and/or complaints are part of their mental illness. Yet, we would suggest, that if you treated any general patient with the same emotional indifference as patients with a mental illness are treated, there would be public outrage.

To put it bluntly, the individual mental health patient rarely experiences empathy, understanding, emotional support, talk therapy, etc. Just about every emotion that is felt or expressed, the service has a medication for. As a result of this grossly discriminatory way of delivering medical treatment and nursing care, patients lose complete trust in the clinical staff, avoid the mental health system, often to their detriment, and can either become "pathologically" compliant, or fight the clinical staff "every inch of the way."

The damage is such that VMIAC staff are yet to meet a patient who has received treatment and care in the public mental health system who has not been damaged by the way care and treatment is delivered by the majority of health professionals.

Nursing: Additional to this, nurses are generally not complying with their profession's Competency Standards, even though they are a requirement of practice.

Nurses conducting holistic nursing assessments, developing holistic care plans, and implementing and evaluating their care plans appears to be almost non-existent.

Nurses appear to have become confused about what their role and responsibilities are in relation to their patients, and appear not to be confident enough to assert that their profession is independent to psychiatry with inter-dependent functions. Indeed, psychiatrists do not appear to understand or accept this very basic tenet either.

This problem would not be too worrisome if it were not for the major negative impact this is having on patient care and the psychiatric nursing profession as a whole.

Currently, the major, if not the only, focus for patient care is containment and medication. For example, there is no attempt to assess or assist the patient to deal with the emotional impact of having a mental illness that may encompass such things as grief, depression, fear, in some instances terror, etc. There is no provision for assisting the patient to develop coping skills, providing them with holistic care encompassing counselling, or even empathy. All you would have to do is pick up a medical file and read it. It would be rare to find a single sentence in the progress notes that covers how the patient might be feeling, and you will find little to nothing in the treatment or care plan.

Put simply, nurses need to get back to nursing.

Models of Nursing Practice:

While many of the services claim to have introduced Primary Nursing Care as a model of nursing practice, in reality they appear to have modified the model so much that it bears no resemblance to the model in theory. While we are not familiar with recent research results regarding this model, past research has indicated that when practised, patients get better quicker, are discharged earlier and have less readmissions to hospital. From a staffing point of view, motivation is increased; staff turnover is reduced as well as sick leave.

Given that patients in inpatient facilities constantly express concern about the lack of nursing continuity, it would seem that an unmodified version of Primary Nursing Care would be of major benefit to patients and staff. As it is, patients appear to have a different nurse each day. If you ask the patient who is the nurse looking after them on a particular day they are often unable to tell you, and moreover will tell you they have not sighted the nurse on that day.

Psychiatrists:

As indicated previously, consumer feedback suggests that the attitudes of psychiatrists towards their patients are far worse than anything consumers experience in the community. That is not to say that psychiatrists do not care about their patients, but rather that they seem to think it essential to hide it from their patients. We are unsure if the coldness and indifference that is often displayed results from their lack of education and practice in communication, negotiation and problem-solving skills, whether it is attributable to their high workload and the stress they feel, or whether they have been unconsciously conditioned to treat patients with great distance. We do know that when it is displayed it can have a very negative impact on their patients. Having said this, it does not explain why we have such good psychiatrists as well. Unfortunately, they do not form the majority.

Additional to this, in conversations with some psychiatrists, they have told us that their workload is such that they are unable to provide holistic assessments and treatment. One psychiatrist even suggested that if any mental health service is claiming to use a holistic approach, then they should be certified because they are clearly delusional.

Given the above situation, one has to question the adequacy of psychiatric training and supervision when the workload is such and there is an acute shortage of psychiatrists.

Overseas Psychiatrists:

From time to time, patients also express concern about the number of psychiatrists employed from overseas, whose skill in the use of the English language can be lacking. Patients also express concern about overseas psychiatrists lacking knowledge of Australian culture, which they believe can often lead to misunderstandings between the psychiatrist and patient. The VMIAC appreciates the shortage of rural-based psychiatrists and the difficult of employing them in country areas. We are also aware of the requirements regarding standards of communication in English. However, given the concerns of patients, strategies to overcome these issues should be addressed.

Recommendations:

(1) **That the DHS conduct a survey of all psychiatrists, psychiatric registrars and nurses to ascertain what they understand about their roles and responsibilities, and what are the issues that impede the carrying out of their roles and responsibilities. The DHS could then analyse the results and make recommendations for change.**

(2) **Consideration should be given to providing a mentoring service to psychiatrists coming from overseas to assist them with language, culture and any other needs they may have.**

Rationale: ***Self-explanatory.***

Occupational Therapy:

A constant concern expressed by patients in inpatient facilities is the lack of occupational therapists and therefore the lack of regular ward programs. The feedback from patients where occupational therapists are employed is always very positive, not only from the point of view that most are respectful, but also that the arranged ward activities are seen as helpful in their recovery.

Counselling:

The lack of counselling or talk therapy, not only from the point of view of the lack of psychologists employed in the public mental health system, but also due to the lack of time available for doctors and nurses to provide this important but totally undervalued service, has been of concern to patients for some time. While we acknowledge that there are psychologists working in the system, they do not appear to be employed to do what they were "trained" to do; and, as stated previously, psychiatrists and nurses currently confine their treatment and care activities to medication therapy.

Clearly, the major factor influencing the lack of counselling services in inpatient facilities is the domination of the medical model approach to care and treatment. It is our view that while this model of practice goes largely unchallenged, a more humanistic approach to care and treatment will never prevail.

Furthermore, it is an indictment on the Australian Medical Association and General Practitioners that they refuse to support the introduction of "free" psychological services via Medicare arrangements. As it is, most patients cannot afford private health insurance. In essence, they are being discriminated against because of their disability and concurrent poverty.

Recommendations:

That "talk therapy" be introduced to all public mental health facilities as an integral part of treatment and care; and further, that psychological counsellors be made available to all pensioners and people on low incomes as part of a Medicare arrangement.

Rationale:

Apart from the fact that it may save some lives from suicide, it is self-explanatory.

Rights:

As indicated, the VMIAC staff visit most inpatient units, primarily to hold patients' rights forums with inpatients. It has been our experience that patients generally have little to no recollection of being given a statement of their rights, and more often than not state that staff have not provided them with a verbal explanation of their rights either individually or collectively. It has also been our experience that some clinical staff have little knowledge of patients' rights, and most do not behave in a manner which demonstrates both an understanding of, and respect for, these rights. For example, anecdotal evidence indicates that in some instances patients have been "reprimanded" for calling our office and requesting an advocate. When advocating, we have on occasions been told, "but so and so is a PD." There have also been instances where staff have denied their patient assistance in obtaining a second opinion, believing that if that is what their patient wants he or she should arrange it themselves without support. This position can be taken irrespective of the patient's status.

Many patients both in hospital and in the community tell us that in reality they do not believe they have any rights. It is our view that this perception will continue while health professionals largely ignore their responsibilities in relation to ensuring and encouraging respect for each patient's rights and assisting their patients so that their rights are realised. Put bluntly, it is not sufficient for health professionals to be aware of patients' rights and then do nothing to assist the patient to implement their rights. To overcome this problem, the VMIAC has developed a basic document of patients' rights and staff responsibilities regarding those rights. We believe that if patients' rights are to be taken seriously then each agency should implement a similar document as a guideline and educational tool for staff. Moreover, providing a statement of rights or a verbal explanation of same should never be seen as a task to get over and done with; it should be seen as an ongoing, continuous process that encompasses all therapeutic interactions with a patient.

Informed consent: While informed consent comes under patients' rights, we believe that it is necessary to highlight our concerns separately as our feedback indicates that it is rare for informed consent to occur in the manner in which it should. For example, we often tell patients that informed consent around medications includes the need for the psychiatrist to inform the patient of the following:

What the drug is;
What the drug is for;
Why the person needs the drug;
What level of dosage is needed and how often;
How long the person will need to take the drug;
What are the side effects of the medication and what the person should do if they experience side effects;
What are the alternatives to the proposed drug; and
Discuss the options with the person and advise them of their rights.

Whilst there are times when the patient indicates that his or her psychiatrist has spent time explaining all of the above, this is rarer than the psychiatrist who does not adhere to the principles of informed consent.

The VMIAC would argue based on patient feedback that cooperation regarding medication is more likely to occur when the psychiatrist and nurses behave in a manner that reflects respect for the patient's right to know and participate in decisions concerning their own mental health and what goes into their body.

Patient Participation in Treatment:

The lack of patient involvement in their own care and treatment as per the Mental Health Act and DHS Consumer Participation policy has always been disappointing. It is almost impossible to convince patients of their right to be treated with respect and dignity if clinicians do not support or respect the individual's right to understand and have a say in their own care and treatment. Moreover, little consideration appears to be given to the fact that it is also impossible to gain cooperation in care and treatment when all effort encompasses imposing care and treatment on the patient rather than putting effort into trying to assist the patient. Anecdotally, the VMIAC's observations have been that where a clinician spends the time gaining their patient's trust and assisting them to understand the need for the treatment, there is more opportunity to receive cooperation rather than protest, and the patient is more able to develop some sense of ownership about the course of treatment for their mental illness.

Second Opinions:

Many patients are of the view that while it may be their right to receive an independent second psychiatric opinion, the time many psychiatrists spend making an assessment and coming to a conclusion regarding diagnosis and treatment can be highly questionable, and in many instances is outside the Practice Guidelines for the Treatment of Psychiatric Disorders. For example, most patients complain that the whole process of assessment and conclusion can take 5 minutes. I am sure you can understand patient cynicism around second opinions and their reluctance to accept the second opinion when this occurs. On the other hand, it has been our experience that on the rare occasion that a psychiatrist does spend time with the patient and comes up with the same conclusions as the treating psychiatrist, the patient is more accepting of the process and the treatment.

Another issue is the difficulty patients have in obtaining a second opinion because of their lack of knowledge of the availability of psychiatrists. We believe that each service should develop a list of internal and external psychiatrists available for second opinions and this list should be readily available to patients.

Additionally, the acute shortage of psychiatrists, in particular in the rural regions, makes it very difficult for this component of patients' rights to be actioned.

Recommendation: **Given that it is the role of every health professional to advocate for his or her patient; and further, that there is a constant breach of the Mental Health Act in relation to the provision of written and verbal information about rights to patients, that there be a review of the Mental Health Act with the view to providing provisions in the Act to facilitate accountability when clinicians fail to demonstrate respect for their legal obligations to their patients.**

Rationale: ***As with culture and attitudes, the VMIAC have been expressing concern about the failure of clinical staff to provide their patients with assistance regarding their rights for many years, with no changes ensuing. It therefore begs the question, what is the point of having a law if there is no requirement to comply with it and no provisions to facilitate accountability?***

Safety Issues: The lack of proactive preventative measures that exist in mental health services generally, but in particular in inpatient facilities, to ensure the safety of all patients is of major concern. Policies seem to only exist to guide staff about what to do after an event rather than to prevent an event from occurring. It is our view that it is the right of every patient to not only be safe, but also to feel safe. Anecdotal evidence would suggest that this is far from the case for many people in inpatient facilities. As indicated previously, the staff of VMIAC visit most inpatient facilities on a monthly basis. It is our experience that when we arrive on the wards, most if not all of the staff will be found in the office. When you consider the criteria for involuntary admission to hospital and that most inpatients now have an involuntary status, it seems a contradiction in terms that people who are a risk to themselves or to others are so often left unsupervised by staff.

The problem is statewide and exists to such an extent that the consumer community has been referring to the ward office as the "fish bowl" for some years. The analogy – the office is made up of mostly glass and the patients stand outside the glassed area watching the nurses and others moving around within the enclosed glassed area.

A number of reasons have been given as to why nurses remain in the ward office while their patients are out on the ward unsupervised. They are:

Habit of practice;

Staff are frightened of their patients (even though the distance nurses create with their patients is a major contribution to the distress of patients);
There is too much paper work to do. (If the level of paper work is such that it prevents you from delivering an acceptable standard of care and treatment then there needs to be a review of the paper work requirements).

Risk Assessments: While risk assessments are a regular activity of clinical staff, they are superficial at best and inadequate at their worst. For example, a patient might be asked if they are having thoughts of suicide. If the patient says yes, they will be asked if they have a plan. If they say no that can pretty much be the end of it. If they say yes, into high dependency they may go, an increase in medication they may have. What they will not have is any exploration as to why they might feel the way they do, what can be done to assist them to feel less hopeless about their situation, etc., etc. A demonstration of empathy is definitely not on the agenda. To paraphrase one Consumer Consultant, "If I tell staff how I'm feeling and they increase my medication, why would I tell them how I'm feeling again?"

Additionally, if nurses were carrying out the role and responsibilities for which they have been trained, they would have an intimate knowledge of each of their patients and be acutely aware of how they are feeling.

Women's Safety: While both men and women in inpatient facilities have expressed concern that they do not feel safe, the VMIAC have specific concerns around the safety of women.

The extent to which women would prefer to be treated on a female-only ward is currently unknown. Having said that, many women have indicated support for the idea.

Given the high proportion of women who have experienced sexual abuse as children, the increase in vulnerability of women when mentally unwell, the risk of entering into relationships with male patients that would not occur if mentally well and the anecdotal evidence provided by patients of sexual assault and harassment, including sexual harassment, on inpatient wards is an issue that needs to be taken far more seriously than it is.

Additionally, there have been numerous anecdotal examples of women complaining to staff about feeling unsafe and nothing is done about it. Allegations of rape and/or sexual harassment are sometimes seen as part of the person's mental illness and therefore not investigated thoroughly, nor is the person treated with any empathy or support.

One anecdotal example of the attitudes displayed towards women with a mental illness who make an allegation of rape occurred recently. The alleged rape took place in a Psychiatric Disability Rehabilitation and Support Service. The staff member investigating the allegation interviewed the woman and the alleged rapist together. The staff member's rationale was that it was only an allegation. The distress this caused to my client did not seem to matter.

Additionally, when men or women are admitted to an inpatient facility there is no specific assessment of the individual to ascertain their feelings about safety or documented strategies noted in care plans to enhance the person's safety.

Recommendations:

(1) **In light of the negative impact the practice of remaining in the ward office has on patient care, its contribution to placing patients at risk, increasing the misuse of seclusion and the distress it causes to patients, that the DHS conduct a statewide survey of ward staff to ascertain clinicians' views as to the reasons for such a practice; and further, the VMIAC at the same time conduct a statewide survey of the impact this practice has on patients. The results should then be compared and recommendations implemented under a Statement of Priority arrangement.**

Rationale: ***Recommendations as to the inappropriateness of this practice were made 15 years ago following the Ministerial Statewide Audit of Public Psychiatric Hospitals and the problem remains unchanged. Additionally, the VMIAC's concerns regarding the continuation of this practice and the negative impact it has on patient care, and in particular on patient safety, have been regularly brought to the attention of the appropriate organisations for nearly 10 years with no attention being given to these concerns. Thus, it should now be time to become directive and prescriptive.***

(2) **That patients' perceptions of their safety form part of nursing care assessments and care planning.**

Rationale: ***Self-evident.***

(3) **That the Mental Health Branch organise a round table discussion with all stakeholders to discuss issues of patient safety, in particular that of women, and explore practice**

options including environmental options in order to enhance safety.

Rationale: ***A duty of care exists to ensure all patients are safe. This duty of care needs to be taken more seriously.***

Seclusion: Given the feedback the VMIAC has received from patients who have experienced seclusion, we would have to conclude that this practice is one of the most damaging treatment modalities in psychiatry. While guidelines and practice suggest that seclusion should be a last resort measure and only occur when the patient is at risk of absconding, or of harming themselves or others, our feedback and in some instances direct observation is that it is a first resort. To be "grabbed" by up to six people, taken against your will to a room, stripped naked in some instances in the most insensitive way, injected and left in the room only to be observed through a window at 15 minutely intervals would be humiliating and traumatic for anyone. Yet patients' reactions, and in particular their feelings about the above experience, are largely ignored from a humanistic point of view. When patients try to talk about the experience or complain about it, defensive reasoning takes over, the issue of the impact of the experience on the patient is ignored, and reflective practice is negated.

No account is taken of the patient's (female or male) potential past history of sexual abuse, the requirements under the Mental Health Act (must be supplied with appropriate bedding and clothing under the circumstances) or the Chief Psychiatrist guidelines. Anecdotal accounts also indicate that some patients are being denied toilet facilities and sanitary napkins have been refused to some women.

In conclusion, many patients have spoken about the practice of seclusion reminding them of their past experiences of sexual attacks. Research from South Australia also indicates that a person is most at risk of suicide after being discharged from an inpatient facility, particularly if seclusion was used.

Recommendations:

(1) **That each patient of the public mental health care system, with their case manager, assess the early warning signs that the patient may elicit when unwell and which may require seclusion, and together, establish strategies that will reduce the likelihood of needing seclusion; and further, that these strategies form part of the treatment and care plan; and that the implementation of same be monitored by the Office of the Chief Psychiatrist during the auditing processes.**

(2) **That part of the seclusion documentation include a requirement to state what clothing/bedding was removed from the patient and why; and further, that the documentation form part of the Office of the Chief Psychiatrist's reporting and auditing processes.**

Rationale: ***Any treatment modality that causes harm to a patient should be viewed as a last resort measure and justifications for its use challenged and evaluated constantly, otherwise its use becomes nothing more than a "habit of practice", loaded with defensive reasoning justifications.***

Patient Satisfaction: While it is appreciated that patient satisfaction surveys are conducted regarding non-inpatients, we believe that it is imperative, given our feedback, that these surveys also be conducted at an inpatient level. Having heard some of the rationale for not conducting inpatient surveys, we do not believe the reasons are sufficient. The VMIAC is of the view that if inpatient surveys were conducted on a regular basis it may reduce the extent of defensive reasoning that goes on in relation to clinical practice, and hopefully encourage objective reflection regarding clinical interventions that can be so traumatic to patients generally. Moreover, it could assist in positive changes to the culture and attitudes.

CATT: While the structure of the public mental health service should provide for the needs of people with a mental illness, it doesn't. Funding provided by government is grossly lacking and the way funds are distributed appears to contribute to the problems in that defensive reasoning and political considerations can often influence funding distribution and decisions, which in turn negatively impacts on patients.

The Crisis Assessment and Treatment Team (CATT) is known in the consumer movement as the Can't Attend Today Team or the Call Again Tomorrow Team. This has come about because of the inability of CATT to attend to patients in crisis in a timely manner. While part of this may be attitude based, most of it is about the lack of funding and therefore the lack of staff to provide an appropriate service to people in crisis.

Anecdotal evidence and constant feedback from patients would indicate that the CAT Teams across the State act more as gatekeepers of hospital beds than anything else. Indeed, some members of CATT have expressed the same view.

There have been regular reports of individual CATT members ignoring patients' and their carers' pleas for assistance.

As an example, a young man came in to the VMIAC office very distressed and suicidal, indicating that he had just been raped by another man. Triage was phoned and indicated that the CAT Team was out of the office and they would phone back. The phone call was made two months ago and we are still to receive a call. Instead the young man was taken by VMIAC staff to the local emergency department.

While the VMIAC does not have the resources to establish a database to judge the extent of the problem, our anecdotal evidence is sufficient to cause us great concern.

Additionally, anecdotal feedback from patients suggests that if the CATT assess the person as not sick enough to be admitted to hospital, they are often left without referral or follow-up. The result is often that the person's mental health deteriorates to a point where they need involuntary admission and police involvement. While the service justifies this negligent practice as consistent with their requirement to treat people in the least restrictive environment, they ignore the fact that the person was asking for assistance and was refused. Moreover, assessments seemed to be based on bed availability rather than patient need and level of unwellness.

Impact: There is a humanistic, emotional and negative clinical impact on the patient community when services neglect their needs. We do not know how many patients have committed suicide as a result of being denied a service, but we have heard reports of individuals who have suicided shortly after being refused hospitalisation and being left to fend for themselves. Additionally, we have had quite a number of patients tell us that they took an overdose or slashed their wrists as a means of gaining hospitalisation. Our feedback also indicates that many patients are just left to deteriorate until such time as they finally get admitted in a much worse state than was necessary.

Recommendation: **As per recommendation made under psychiatry and nursing.**

Emergency Dept's: From time to time consumers come in to our office when they are unwell and requiring assistance. As we most commonly can't get a response from the local CATT, we will often take the person to the local emergency department.

No matter how emotionally distressed, consumers are often required to sit in the waiting area with the general patients for hours. The fact that they are crying, in some instances sobbing, talking about their issues so that everyone in the waiting area can hear what they are saying, is not considered. Our observations suggest that consumer distress, emotional pain, their issues, pacing, etc., are seen as far less agonising than physical pain.

Recommendation: **That DHS conduct a review of all emergency departments to ensure that people with a mental illness are seen promptly; and further that a room(s) be made available for mentally distressed patients to wait away from other patients.**

Transport: As with seclusion, the method of transporting sick people to hospital handcuffed and in the back of a police van is often described to us in very traumatic terms. In discussing these matters with individual members of the police force, concern exists that CATT over-use the services of the police.

Discharge plans: Anecdotal evidence would suggest that there are major problems with appropriate discharge planning. The main problems are people being discharged too early without appropriate accommodation or provisions for ongoing support to ensure the person is adequately cared for after discharge. While the policy indicates that discharge planning should commence on admission, in practice, anecdotal evidence and medical records would suggest this rarely occurs. Indeed, we have heard horror stories of people being discharged to the street, or to a hotel where the cost can use up the person's pension within a matter of days, leaving no money for food or the purchase of medication.

The main reason for the above problems when you talk to staff is the shortage of available beds.

The problem of homelessness is also of major concern.

Another issue that is often raised by patients is their discharge from the public mental health system and their inability to get back into the system when necessary.

ISP's: The theory of Individual Service Plans (ISPs) is excellent, including the concept of patients actively participating in the development of the plan and using the plan to guide individual care and treatment. While the staff of the VMIAC have seen some excellent plans and observed some staff use the plans for the purpose for which they were meant, unfortunately this is the exception rather than the rule. We have also seen medical file progress notations that largely ignore the established plan. In other words, the ISP is completed as a task and then can just sit in the front of the file not to be sighted again until next up for review. Some ISPs are clearly incomplete.

Mobile Treatment & Support Teams:

The notion of mobile treatment and support teams is excellent. Having said that, from time to time we have heard reports of members of the team attending the patient's home, handing him or her their medication and immediately leaving. It would seem to us that part of the role ought to be about ascertaining how the person is going, if they have any other needs and ensuring compliance with taking the medication (in a respectful way) if the person has a history of non-compliance.

Case management:

While the principles behind the introduction of case management were excellent, the major problem has been implementing the guidelines. For example, the guidelines indicated that all people using the public mental health system were to be allocated a case manager. In practice this does not occur, and those that are allocated a case manager often complain that they can't get in to see them. In discussing these problems with case managers they more often than not indicate that the problem is one of lack of staffing resources and unrealistic workloads.

Debriefing:

While we are aware that in some instances staff debrief clients about traumatic experiences they have had with services, these debriefings are exceptions rather than rules of practice. We are also aware that some theorists argue that debriefing is not all that helpful, and in some instances can make the situation worse. What the VMIAC would suggest as an alternative and an essential part of everyday practice is empathybriefing (the writer's terminology). It would seem to the VMIAC that if the relationship between patients and staff is to become one of mutual trust and respect, then there needs to be an acknowledgment and display of empathy about the human impact of having a mental illness and everything that goes with it, including sometimes being required to endure some of the more traumatic and intrusive treatment and care modalities around.

Suicide:

The extent to which people have suicided because of the failure to provide services, because the services negate the feeling side of mental illness, the inability to provide holistic assessments, treatment and care modalities, the shortage of hospital beds, etc. is unknowable. What we do know, however, is that we are turning carers into consumers when their children have suicided; and in particular, when in their view, if the service had listened to them their son or daughter would be alive today. The depth of distress carers go through after losing their son or daughter is distressing in itself, without them realising after the Coroner's Inquest that the whole process has been a waste of time and nothing beneficial is going to be learned from the death of their son or daughter.

By way of example, each parent that has been provided with an advocacy service after the suicide of their child has indicated that they want to go through the coronial processes because they do not want their son's or daughter's death to be for nothing. The superficiality of the inquest and the lack of in-depth questioning of the clinical staff have overwhelmingly distressed each parent who has been through the process. On speaking to the Coroner about these concerns he indicated that funding is not provided to conduct psychological autopsies and that their powers are limited. Given the high rate of suicide, restricting the Coroner's Office from in-depth analysis is an appalling situation.

From the observations of the VMIAC, it would seem that the Coroner's Office is not aware of the nursing profession's Competency Standards (a requirement of practice) because there have certainly been no questions levelled at nurses as to why no assessment or holistic care plan was implemented. In one instance, a patient was on 15-minute sightings, which were noted in the file from 0900 to 1050, despite the fact that the patient jumped in front of a train at 0910. No accountability occurred or fault was found. The parents were devastated, especially since after the police had contacted them, they had phoned the hospital and were told their son was okay when in fact he was dead.

The response to the rate of suicide of people in the public mental health system appears to have joined the habit of practice scenario; that is, if enough occur it becomes just one of those things. The VMIAC's position is that one unnecessary death is one too many. Because of our position, and the number of suicides that have occurred, one gets very tempted to ask the government how many suicides do you think have to occur before it becomes statistically relevant or relevant to your re-election?

Recommendation: **That funding be provided to enable Coroners to conduct psychological autopsies in instances of suicide.**

Rationale: ***Self evident.***

Complaints Systems: While the VMIAC is aware that it is the right of patients to complain, given the complaints about internal and external complaint systems we thought it deserved special mention additional to the comments under the rights heading.

Defensive reasoning appears to be at epidemic proportions when it comes to patients making complaints about services and clinical staff. Defensive reasoning is elicited by blaming the victim (or their mental illness) for everything. If the person has an advocate to assist them in the complaint and the advocate refuses to go along with the defensive reasoning, much effort is then made to discredit the advocate, including telling untruths; and if this doesn't work, telling lies. As a consequence, the issue that forms the basis of the complaint can often get lost and is never addressed. Accountability for poor practice and for engaging in cover-ups is virtually non existent.

Another consequence of this practice is that most patients regard internal and external complaint mechanisms, including supposed independent agencies, as tokenistic at best. Generally the culture is such that if you have a mental illness and make a complaint your allegations will automatically be seen as wrong and largely part of your mental illness. In contrast, the clinical manager's response to patient complaints appears to be always accepted as correct, even when you can demonstrate deliberate misquoting of file notations.

Service Gaps: On the whole, the only service gap that exist is the inability to implement policies to their full potential because of the lack of financial and human resources.

Selection Processes: The VMIAC has had concerns for some time about the processes used to select health professionals for committee work, in particular work undertaken by governments and bureaucracies. Our concern is that it is not all that uncommon for health professionals to be selected without due consideration of the attitudes the person displays to and about consumers. To be blunt, anecdotal evidence exists that many people selected for committee work have reputations for being quite disrespectful and indifferent regarding consumers generally. Moreover, some have been known to falsify information in order to cover up negligent acts and engage in abuse of the whistleblowers. As a consequence, these processes can become an exercise in cynicism for the consumer movement generally. We understand that it is difficult for those working in the bureaucracy and governments to have an intimate knowledge of how individual health professionals behave "when the door is closed" and there is only the health professional and consumer in the room. However, we believe it is imperative that this matter be considered in all selection processes. It is simply incorrect to assume that because someone holds a senior position and is active in their profession, or treats the "selectors" or their work colleagues with respect, that those behaviours automatically flow on to encounters with patients. They simply do not.

Consumer Participation:

The VMIAC also has concerns about consultation processes generally. Firstly, the VMIAC and other consumer representatives are usually consulted after decisions have already been made and/or the agenda is established.

The view of Victorian consumers and the inadequacies of the services provided are well known to both Commonwealth and State governments and their representatives. The VMIAC puts in a six monthly reports to the Commonwealth and an annual report to the State.

In our opinion, consumer participation largely remains tokenistic. Additionally, the processes of consultation rarely allow sufficient time to consult consumers in a manner that gives them much thinking/reflection time to enable them to fully participate. Everything is always rushed to a point that precludes genuine participation and consultation. The VMIAC's meagre staffing levels also inhibit our ability to provide education to consumers about the issue so that they are more able to make an informed decision. A good example of this is the introduction of consumer outcomes, where some consumers were invited to choose an outcome tool without any education on the subject.

Selection processes for consumer representation are also highly questionable and in some instances discriminatory and/or political. For example, there was a recent review of VICCAG and the Ministerial Advisory Committee (MAC). The latter had been held in abeyance since a change in Minister took place. While the VMIAC supported a review of the information provision processes, we were not consulted. We understand that only one consumer with no experience of the public mental health sector was consulted, even though he says he wasn't. This is not consumer participation. Moreover, a letter from the Minister to the Director of the VMIAC indicated that one of the key priority areas was consumer and carer participation. Yet the Director was not invited to continue on the Ministerial Advisory Committee, even though we are the only consumer organisation that can provide a statewide perspective. The VMIAC's chairperson was invited to join the MAC, knowing full well that she was extremely physically unwell and would not recover and that the Committee of Management do not get involved in the day to day issues of the VMIAC. When you look at the membership of the recent appointees to the Committee one can only conclude that this is an exercise in controlling consumer participation rather than enhancing it, and it borders on discrimination. That is, it appears to be no accident that consumers are often appointed as representatives who simply are unable to perform the task for a variety of reasons. In reality, this is about non-consumers maintaining control of the agendas and everything else that goes with it.

While some organisations appear to be genuinely committed to consumer participation, anecdotal reports from consumer consultants and consumer representatives persistently and consistently indicate that the attitudes of many service providers, managers and bureaucrats are that consumer participation exists because it has to rather than it needs to.

The view of the VMIAC is that if we do not "move outside the square" (the square is a major part of the problem) to identify the problems, discuss them without fear or favour and come up with more creative ways to address the problems, then nothing will ever change to benefit those on the receiving end of service delivery.

Non-Clinical Issues

PDRSS:

Many of the issues and complaints consumers make about the clinical sector are repeated about the psychiatric disability rehabilitation and support (PDRS) sector. Issues of concern include stigmatising attitudes, staff acting like clinicians, failing to deal with complaints about service delivery, denying consumers the right to participate in service delivery, or displaying tokenistic practices. Having said this, there are individual PDRSSs that are very respectful, inclusive, and responsive to consumers.

We also have concerns about what appears to be a reduction in "Drop-in" services, which consumers consistently say play a major role in their recovery. One assumes that the reason for such positive feedback is that this service is confined to consumers spending time together, enjoying each other's company, facilitating their capacity to meet people and make friends. In other words, the mental illness is given a rest and the person is able to come to the fore.

Regarding funding to the PDRS sector, including our own service, it is grossly inadequate and seems to demonstrate a lack of understanding of the positive contribution these services can make in assisting people to remain well and in some instances move on.

From the VMIAC's point of view, funding priorities work this way: the first priority is the bureaucracy, followed by clinical services, followed by PDRS services and then the VMIAC. We will always be last on the agenda until the decisionmakers open their minds, close off their attitudes and cease to behave like they are nothing more than a habit of practice.

Homelessness: Data suggests that up to 80% of the homeless population has a mental illness. The ability of services that provide accommodation, support and placement services to assist people with a mental illness is stretched to the limit.

Being able to access affordable accommodation in the private sector is almost impossible.

Unemployment: We are informed that the level of unemployment for people with a mental illness is around 75%. While there are services to assist consumers to gain employment the success rate is obviously not that good.

Additionally we have heard stories of employed consumers being found to have a mental illness and having to endure inappropriate comments. For example, one casual worker came in to our office for support after having just been told by his boss that his services were no longer required. Apparently he was sighted taking his medication and was accused of taking illicit drugs. He revealed this was not the case, and that his drugs were prescribed for a mental illness. He had been working for the company for around 6 months when he was dismissed.

Poverty: The level of poverty amongst people with a mental illness is heartbreaking. Anecdotal examples of women being forced into prostitution are not rare. Begging in the street is now commonplace. Having no money to buy food, clothing, medications, catch public transport, etc. has become a way of life for many. It's a public disgrace.

Dual Diagnosis: While policy development and services are in place to assist people with a dual diagnosis, there remains a problem with services working together. There are still pockets of "We cannot assist this person until their drug and/or alcohol problems are addressed," or alternatively, "We cannot assist this person until their mental health issues are attended to."

Two Tier system: Finally, while the VMIAC recognises the large number of people who are currently experiencing high prevalence mental disorders and the need for governments to pay attention to the issues including providing funding, we have concerns that a two tiered system of illness is being created, such that the needs of people with a low prevalence disorder are being neglected in every way, including funding. This is having dire consequence for many people and their families. To stress the point, people with a diagnosis of schizophrenia, bipolar disorder or personality disorder are the most neglected people in the mental health care system and it is costing lives.

Summary: While this submission has concentrated on the issues of concern that are regularly raised by patients and consumers, we would like to acknowledge those who work very hard and ethically to make positive change. We believe that if the above concerns can be addressed then we will be 99.9% there in delivering a service that is patient and consumer responsive and respectful. If the VMIAC can assist in brainstorming solutions with you we would be more than happy to assist.

Isabell Collins
Director