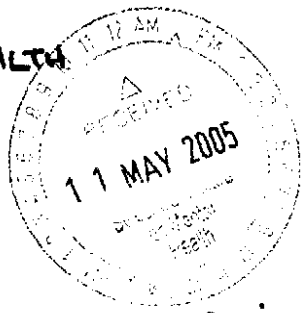
To: COMMITTEE SECRETARY
SENATE SELECT COMMITTEE on MENTAL HEALTH
DEPARTMENT of the SENATE
PARLIAMENT HOUSE
CANBERRA ACT 2600



06.05.2005

IVAN D. CARNEGY
[redacted]

(1)

I find the terms of reference slightly restrictive however will attempt to work within them where possible.

∴

(a) it seems the funding for the National Mental Health Strategy is inadequate as at the point where the mentally ill actually interact with services it is, to say the least, woeful.
A very senior person responsible for mental health care in Victoria informed me that of every ten dollars spent in care provision (capital works/recurrent expenditure) the Federal Govt. gives one dollar.
Realistically in order to achieve world "best practice" the Federal Govt. should, in an ongoing manner, provide an extra $8 & within that $10.
That being said, using the above State example, the Vic. Govt. should continue its current contribution. Ditto other State + Territory Govts.
This approach should give a reasonable basis to achieve the desired outcome.
Obviously allowance should be made for items such as building cost increases, maintence programs, salary increases.
At Federal + State Govt. level in particular, the bureaucratic structure should be flatter.
While a Regional Director with a small support staff may be beneficial, competent authorised psychiatrists, senior nurse clinicians + managers at the direct care level should be able to what I believe is the underlying goal of this Committee. The value of social workers + occupational therapists should not be forgotten.
The dollar savings can then be redirected to direct care. It should be noted that very few senior managers were 'retired' during + following the 'de-institutionalisation' process; the boys + girls seem adept in surviving changes in policy. I do not condemn, merely observe, as there are such individual concerns not the least rearing children + paying off mortgages, let alone ambition.

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IVAN D. CARNEGIE
[redacted]

(b) The focus in recent years on prevention + early detection is good + will save trauma +, in the future, money which can be directed to ongoing care of the mentally ill.
However more acute beds are needed.
In Victoria there has been the introduction of step-down/step-up units (essentially medium term beds); this enables people to further "wind-down" from acute admission, facilitate their reintroduction to the community, but also allow transfer back to acute unit if — due to pressure on beds — they have been moved too soon.
I believe that the more of both type of units that are developed + appropriately staffed, the gross + ongoing problem of the "revolving door syndrome" will be reduced.
Given sufficient step-down/step-up beds I can see no impediment in using some of these for respite care. Direct care paid people have routine time off + holidays. Families do not generally have that "luxury"; their mental + associated physical health needs addressing.
As to community care + 24/7 crisis services I have to query what the former means. There are outreach teams, probably insufficiently resourced, who are there to support the mentally ill in the community.
I ask therefore, are the people who were "shoved out" into Supported Residential Accommodation during the "de-institutionalisation" process also being helped?
Are there mental health specialist staff available at every community health centre? If not, why not?
With regard to the crisis services, the first team set up in Victoria enabled two staff to go out "after hours", with a psychiatrist as back-up, to treat an acute episode in a person's home or in a dedicated house. Now one staff goes out, + in one case where a private psychiatrist "certified" the person requested a second opinion from the team psychiatrist, was refused by the nurse, + the only option given was "ambulance or police".
Mental health care/funding has obviously deteriorated.

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IVAN D. CARNEGIE
[redacted]

(b) continued.

Returning briefly to community care, cluster housing units have no seclusion room/area which can be used according to law to temporarily defuse a dangerous situation. Staff now have to call the police to remove the mentally ill person.
At the time one cluster unit was being set up, such professional o.H.S. issues were ignored by the powers that be.
Not a good option for either consumer or staff.
Client groups such as the (Vic.) North Eastern Alliance of the Mentally Ill access housing with difficulty, possibly because this area is expensive; recently roughly 17¢ people needed ongoing accommodation.

(c) To reiterate, a flatter structure is needed — thereby use of funding can be maximised in direct care.

(d) Some time ago I visited a friend in an 'acute' private sector unit; the unit was largely full of medium to long-term mentally ill people previously cared for in the "institutions".
I am really not sure of the funding arrangements for this scenario.
Groups such as NEAMI need more access to housing + support services; not so easy in an expensive area.
Agencies such as the Salvos have a primary focus of providing food/shelter for the dispossessed but not necessarily the 50% of the homeless who are mentally ill.

(e) Supported accommodation people need activity programs whether on site, using community facility such as the Y.M.C.A. or both. Their current choice seems to be the T.V.. To get active involvement outreach staff + transport are needed.
It is heartening to note advertisements in the local press calling for volunteers whose role may encompass some of these needs.

06.05.2005

EVAN D. CAANEGM
[redacted]

To: Senate Select Committee on Mentally Ill

(f) to address "people with complex + co-morbid conditions of drug + alcohol dependence" you need specialist mental health staff with an overlay in those other areas. The existing staff are rapidly reaching retirement age. Recommendations re education included in the Australian Health Workforce Advisory Committee report (Dec. 2003) needs to be fast-tracked + expanded.

(g) try training both bodies such as NEAMI + student nurses (with a high level of practical placement) to train/assist families etc in coping/care mechanisms.

(h) I have an inadequate knowledge base to comment, much of my initial training as a mental health professional now forgotten.

(i) I prefer this comment based on a loss of some $40K over 3 years in income + overtime when I temporarily resigned from mental health nurse to undertake the initial D.ip. App. Sci. (Nursing) in Victoria. It was worth it, that 1/2 tutorial; I have carried it with me ever since.

Translated to this context "I am a bi-polar disorder/schizophrenic etc" — "I am a person who has bi-polar etc", assuming the psychiatrist got it right. A diagnosis basically has value as an R/ guide + for statistics.

(j) The mentally ill are overrepresented in the prison population + what might clinically be termed "dual diagnosis" does not seem to be addressed in even the most recent studies.

I suggest the significant proportion of the mentally ill + dual diagnosis among the prison population has grown since the demise of the institutions.

No government, Federal or State has committed to providing sufficient beds for these people.

If both do (refer comment re (a), page 1 of submission) then much of the problem should be resolved.

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IVAN D. CARNEGY
[redacted]

(j) continued

It is more humane, appropriate + cheaper to nurse the low level recidivist prison population in the community, + by + large prevent or minimise this "revolving door" situation.

The mental health + prison systems, + the sentencing bodies have always interacted + will continue to do so. The mentally ill need specialists to keep them out of the prisons.

With this opportunity to comment I include an observation from a retired senior nurse clinician who had extensive experience – both "institution" + "community" in the U.K. + Australia:

There is a 30 year cycle of "institution" → "community" → "institution" (I would add ad infinitum)

The people in (j) are in prison or the precursor environment, homelessness. Some are supported in the community; the funding is highly inadequate. We are roughly midway in that 30 yr. cycle. The population will get tired of stepping over + around the mentally ill + dual diagnosis on the street, the ongoing reports which don't seem to get govt. attention/funding.

The challenge before this Committee therefore is to achieve a set of recommendations to the Federal Govt. that will actually work.

The concept of 'asylum', nowadays scorned, can be achieved by purchasing properties near parks. In the mid 1980s, pre-"deinstitutionalisation" patients/consumers/clients were asked if they would like to remain. The answer by the voluntary consumers is obvious (but ignored by the zealots); of the involuntary residents roughly 60% wished to remain.

Perhaps some of the above have shelter + food in their bellies in the prison system.

"An ounce of prevention is worth a pound of cure".

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IVAN D. CARNEGY
[redacted]

(j) continued.
I am told that the mentally ill among the prison population in Vic. — Metro Assessment Prison + Barwon - can take their concerns to the Prison Visitor + Ombudsman, but that "gazetting" those units may discourage the mentally ill from seeking assistance in fear that they may be "certified".

A different ministry informs me that there is no requirement under laws for a "gazetted" facility to treat only "certified | involuntary status" people. It is the integrity of the relevant authorised psychiatrist upon which rests minimal "certification".

I believe that in Victoria + elsewhere, such prison units should be regularly visited by - in Victoria - (voluntary) Community Visitors trained under the Office of the Public Advocate, reporting annually to Parliament. To paraphrase — "one in 6 or 7 prisoners would have (been) in a psychiatric unit" (Deloitte, Feb. 2003)

(k) given there are sufficient admission + step down | step up beds, intelligent care-unit design, highly trained staff, this should be minimal.
I believe if a bolus (then maintained) injection of funds for capital works + direct care recruitment | retention is the outcome of this inquiry then "detention + seclusion" will be minimised.

(l) Jeff Kennett's "Beyond Blue" has been given more funding; other not so high profile groups may need the same.

(m) If 50% of the homeless are mentally ill then 50% of the housing should be for the mentally ill — with support services.
Law enforcement can deliver acutely mentally ill to hospital; reports are that many spend inordinate time in casualty.
∞ more acute beds, step down | step up beds, + crisis staff who can manage the transitional phase both ends.

n) I have talked with mental health research staff intermittently over many years + they are brilliant but need funding.

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(n) continued

I perceive however that different bodies might have different terminology that makes correlation of data somewhat difficult. For eg. No Fixed Address = No Usual Address = Staying with Friends. Perhaps one overall heading nationally, perhaps subsections. Give these people funding + then read + listen - there is a difference - to the reports.

(o) ask the people mentioned in (n)

(p) the potential is great in disseminating information (basic) + advice (practical) all over the nation.

Never forget however that it is the highly trained nurse practitioner in the mental health field that is the backbone on which the success or failure of care delivery rests.

My challenge remains contained in my response outlined in (a), page 1 of my submission.

Would this Committee, the Federal Health Minister + Treasurer, State counterparts + all bureaucracies care to take it up + actually do something

Proportionally the mental health budget within the overall health budget should be equitable.

Why delay? This is the opportunity to permanently break the 30 year cycle.

In summary, beds, beds, beds or support services.
Governments come + go. The mentally ill + their needs always remain.

Ivan D. Carnegie
ex-psychiatric nurse (17 yrs.)
ex-(voluntary) Community Visitor, Vic. Mental Health Act.