Submission to the Senate Select Committee on Mental Health

May 2005

Recommendations arising from the narrative which follows:

- *Resources need to be provided for education at all levels of society concerning what mental illness is, what the symptoms are and what to do about it. Teachers, in particular, should be trained to spot and take appropriate action for young people in the early stages of mental illness.*
- *Some of the most effective educators are people living with mental illness. They can help those with mental illness, carers and family, and the community at large to understand what is happening in ways that no one else can. However, their involvement in education needs to be more than token and needs to be properly paid, taking into account also that there may be times when they are not able to participate in this work through illness.*
- *The police are often the first to deal with people with mental illness. There needs to be much greater training of young officers in the necessary skills. A day or two at the academy is not enough. There should be sufficient mental health professionals on call or attached to the police so that they are on the spot quickly and the police do not have to do their work.*
- *Despite some excellent, highly skilled and experienced doctors and nurses in the mental health system, there are not enough of them and they do not have sufficient resources. There are also too many who are not sufficiently skilled or who, for other reasons, are not suitable to work with the mentally ill. Money needs to be found to provide the salaries and the conditions to attract and train enough of the right people. It takes time for people to gain experience and every incentive should be given to retain people over many years and for younger health workers to learn from the older ones. Developing ongoing personal relationships of trust between clients and health staff is critical.*
- *Often people with mental illness have a dual diagnosis, many with an addiction. More health professionals with knowledge of twelve step programs*

and other therapies for addiction are required. All health professionals should be well-educated regarding drug and alcohol addiction and eating disorders, as these are frequent problems for the mentally ill.

- *There needs to be more resources of every kind and better coordination amongst those charged with the care of the mentally ill so that people with mental illness are noted and kept track of, whether or not they have a family to advocate for them, and whether or not they come to the attention of the police. It should not require a complaint to the police to get a person with mental illness to the hospital; health care professionals should have at least equal powers to get a person to hospital for examination and should feel confident to exercise such powers. The guarantee of appearing before an independent magistrate within five days is a safeguard against wrongful detention.*
- *Nevertheless, increasing the legal powers for health officials to hospitalise people against their will should be treated with caution. It could be that some people will be lost in the interests of others having the opportunity of learning to live through repeated bitter experience of illness. I don't know. It's a difficult question and requires serious and thoughtful consultation with mentally ill people before any changes in the present system should be made.*
- *Hospitals must have sufficient beds and resources for people with mental illness to stay as long as their recovery requires and to be provided with appropriate therapeutic programs, along with drugs.*
- *Emergency rooms (at least of large hospitals) should be staffed with a psychiatrist or have a psychiatrist on immediate call and more psychiatrists need to be located in country areas.*
- *There is an urgent need for increased staffing levels, better training, higher wages and improved conditions so that mental hospitals retain experienced and capable staff at all levels.*
- *Mental Health Facilities must be open to public scrutiny and a non-punitive code of practice/ethics needs to be developed for those supervising them so that so that workers are not fearful and indeed feel*

ethically obliged to bring poor conditions and problems to light. It is incumbent upon the members of all political parties to de-politicise mental illness and not to make any capital out of any mistakes that may be made in this area. Education of the media and a code of ethics for them regarding mental illness should also be developed. Hopefully, this will help create a climate in which improvements can be made.

- *There is an immediate need for a large increase in resources for therapeutic and social programs for the mentally ill, including individual therapy, group therapy and occupational and living skills, both inside hospitals and in the community. Where necessary, this needs to include transport, meals and follow-up to assist people to attend these programs. Art programs are all very well, but mentally ill people need and are capable of more than this – as well as art programs too, of course.*

- *Some of the most effective support and advice for people suffering from mental illness and their families is provided by people who share the same problems. There is a need to strengthen and expand the role of so-called "consumer consultants" and make their work in the community a reality,*

- *There needs to be a coordinated approach to the welfare of people living with mental illness, building upon an enhanced role for the community mental health centre. A team approach is needed, with a case-worker for each client, including long-term suffers, but giving the case-worker a case load that they can actually service adequately. The case worker needs to coordinate sufficiently regular and frequent appointments with both a psychiatrist and a GP for general health (often neglected), regular, structured group and individual therapy as required (not doled out in token amounts), and input from a social worker with full information about available housing, work and other community resources. Entry into work, where at all feasible, should be coordinated through this team approach. Liaison amongst centres, hospitals and state to state needs to be maintained as people with mental illness often try to escape it by moving from place to place.*

- *Work programs tailored to the needs and abilities of people with mental illness, paying sufficiently* *well to be attractive and leading to genuine skills training, are needed both in the community and within hospitals. Similarly there needs to be a revival of part-time and full-time disability places, including for people with mental illness, in both public institutions and private industry.*

- *Greater efforts need to be made to provide a range of affordable housing options for people with mental illness. For people who do not require a supervised group home but are not likely to function well in ordinary public housing, other options, such as co-op housing with occasional supervision should be developed. Efforts should be made to find out what kind of housing might be an option for people now living on the streets.*
- *The disability pension needs to be increased – if not in terms of money then through the provision of free medication, free transport, free education and other benefits.*

Observations from my daughter’s ten years of mental illness

Background

I am a well-educated woman, 62 years old, with broad social horizons and community experience. I have made documentary films amongst all sorts of people in all sorts of situations. However, I had so little experience or knowledge of mental illness prior to my daughter’s becoming ill ten years ago that I did not at first understand what was happening to her. She was at university, but her teachers also did not know what was happening, even though one commented to me about an incomprehensible paper that she had written. However, just at that point I was fortunate to be befriended by a young man, whom I will call “S”, who has a long history of severe schizophrenia and considerable experience of the health system. “S” helped me through those first years and later became the subject of a documentary which I began but ultimately decided to abandon. During the period of my daughter’s illness, through my constant contact with “S” and his friends, through contact with doctors and health workers, and through my work on the documentary, I have been able to observe and think about the support available for people living (and dying) with mental illness.

Trying to get help

I first became aware of my daughter’s illness when she was 22 and living in a nearby suburb – sometime in 1995. At first she evaded the efforts of the family to help her and was almost impossible to catch hold of but she finally ended up at home, in a clearly psychotic state, and from this position her father and I attempted to get her to some help. It was then that we discovered that the Community Mental Health Centre in the inner suburb of Sydney where we were living at the time, and the crisis team connected with it, were worse than useless.

We were desperate to get my daughter into hospital and to some sort of help and took her to a local psychiatrist who rang the Community Health Centre and also a psychiatrist at RPA Hospital, but there was no action or coordination and staff working the various shifts at the health centre kept not getting messages passed on to them. As I remember, there was a prolonged merry-go-round of referrals that were required but never got there and this went on for weeks without our being able to get any help at all. And when we finally got the Crisis team to visit my daughter at her father's house, they (as with a subsequent team later in Lismore) were persuaded by my daughter that her only problem was her eating disorder and that she should not go to hospital. Indeed, on that first occasion, the member of the crisis team told me that it wouldn't be very nice for my middle class daughter to mix with the very crazy people that were in the hospital wards! (I now know that these "crazy people" are the best people to help others accept and deal with their situation. And getting to know them is one of the benefits of being in hospital.)

I can no longer remember all the foul-ups of that first period, but they were considerable. I ultimately got in touch with the well-known doctor who headed the area mental health. She said she was appalled and that she couldn't have this sort of thing happening in her system and immediately gave us a referral to a leading psychiatrist at RPA. He gave my daughter a referral to the eating disorders clinic at RPA where she was seen by a doctor who gave her an appointment to see a dietician as a first step in her treatment. And so that was the end of it. Just so you understand, this was a girl who was often hallucinating, lying in bed screaming at unseen people, seeing words written on walls, being persecuted by yoga teachers via telepathy, whose language was sometimes confused babble, etc. However, she had (and still has) sufficient cunning and strength to dissemble and hide these things from strangers – at least for a period of time. Plus very good manners.

On a later occasion, her father and I were able to get our daughter to emergency at RPA. We waited five hours for the resident psychiatrist to arrive from the ward, trying to keep her from leaving as she began changing her mind. (There have been longer waits by other mentally ill people I know – one admission took eleven hours!) Ultimately, the doctor examined my daughter and despite her denials of what was happening, offered her a hospital admission – which she refused. My daughter had then been sick (to our knowledge) for many, many months and I had discovered how important it is for future recovery to get a mentally ill person on to medicine as soon as possible. So I felt desperate about it but was not knowledgeable enough to take the hint from the doctor that if only we would testify that she was a danger to herself or to someone else, he could admit her without her agreement – but only then.

At that time, if I had understood, I would have told that lie. However, now – in a confused way and reluctantly – I agree with the present standards of non-coercion -- that to a point people have the right to run their own lives, whether mentally ill or not, and to make their own decisions. Now that I know so many people with mental illness, I can’t say whether or not they would be better off if health authorities were given more coercive powers than they have now. I suspect that it would not help their situation. Perhaps it is an illusion that if I had been able to coerce my daughter into help and hospital earlier on she might be better today – I suspect it is just a fantasy

Yet, in fact, ultimately, it was only through coercion that my daughter did get help. For a couple of years, my daughter – still very ill -- wandered back and forth between the Northern Rivers area of Lismore-Byron Bay and Sydney. I managed to keep in close touch with her while she was away, and then a friend in Lismore told me that she was wandering the streets screaming, After repeated calls to the community mental health centre in Mullimbimby, a crisis team worker visited my daughter who was in bed in the middle of the afternoon. My daughter managed to persuade the crisis team worker that she was all right but, as I eventually found out, when I got the worker on the phone again, persuaded the worker that it was her mother who had the mental illness! A few days later the police picked my daughter up and she was admitted to Richmond Base Hospital, Lismore. Unfortunately, they did not have room for her there, so she was discharged after two days – not being regarded as harmful to herself or to others. However, she was taken before the magistrate and an order was made for her to receive medication (very much against her will). This began some steps towards recovery although for several more years, she continued to travel back and forth from Sydney, with occasional hospital admissions when she went off her medicine. I used to hope that the police would get called so that she could get to help. They are the only ones with those powers – certainly not family, and not, it seems, the health workers unless the symptoms are really florid and the person seems a danger to themselves or others. In the case of “S” and his friends who are long-term sufferers, it is usually another person with mental illness who takes responsibility for trying to get a person in psychosis to hospital, as they are not visited by mental health workers except when called – and even then, the workers are often too busy with worse cases.

On one occasion, my daughter was living in a derelict bus behind a house where I could ring her and I realised that she was becoming very ill indeed. I went up to Byron Bay to see her. She was not eating and was completely delusional. I got in touch with the health centre and told a sweet young case-worker that the situation required help (my daughter now had a nominal case-worker). The caseworker agreed -- but – again – they could do nothing without my daughter’s agreement (even though she was so ill) – not enter the bus to talk to her, nor send around a doctor to see her for her physical complaints, nothing. There was nothing I could do.

One thing I came to understand clearly over these years of dealing with and talking to the crisis teams and the staff of the mental health centres is that the system is so under-resourced that they must deal with the life and death cases first and other cases necessarily come second. This is a brutal reality which should not exist in a civilised society. Nor should people with families to advocate for them get better attention than those without. Many mentally ill people fall through the cracks – you meet them on the streets now all the time, women as well as men.

I now understand why many families let their mentally ill children go – the situation seems impossible and the person with mental illness often does not respond, does not learn, does not show up, changes his or her mind about nearly everything almost daily, and is adept at lying, stealing – whatever it takes to survive.

Despite the seeming hopelessness of my daughter’s situation, however, I kept in touch, ringing the mental health centre, asking them to check on her, and ultimately, when my daughter went down to 43 kilos in weight and her life was deemed to be in danger, they finally took her to hospital. This time she was there for two weeks, her longest stay in a public hospital. The team at the hospital got another order for medication and tried to get a housing order, but that failed when my daughter opposed it. Ultimately, after an unhappy stint in short-term emergency housing, my daughter returned to live with me in Sydney. She has remained in Sydney now for nearly three years, having learned that running doesn’t help. In an attempt to stabilise her situation, I made it a firm condition of her living with me that she take her medicine which she got from the health centre by injection (but only if they came to her as she did not keep appointments and would not take medicine herself). And, also, she and I had a weekly appointment with a very experienced private psychiatrist/therapist who was willing to bulk bill, and this definitely improved both her thinking and mine. This sort of private help is, of course, not available to most people with mental illness. Moreover, now that my daughter is not living at home, it is impossible to maintain this structure around her and she no longer gets any of that kind of support.

Another doctor who has helped is in Lismore, Dr. Glenn Fuller. If he sends you a submission, it is worth paying special attention to it. He is one of a number of highly skilled doctors and nurses who still stick with the public health system and are a lifeline. Over the years my daughter was up North, she was able to see him for about 15 minutes once a month. That’s not much compared to the therapeutic help that people with money can get, but they were 15 very helpful minutes! Uniquely, she rarely missed her appointment with him. If she were still able to see a doctor like that through a mental health centre today, she might still be taking her medicine. And imagine if patients could see an excellent psychiatrist for more than 15 minutes a month! In

Sydney, where there are so many people, they don’t even get that.

Living with mental illness

My experience of people living with mental illness and the resources available for their survival and well-being extends over the past ten years in the inner west suburbs of Sydney. My observations arise from my friendship with “S” and others I have met through him and from my daughter’s situation. Also, of course, from my intention of making a documentary film about and with “S” (as consulting producer). “S” lives well with mental illness, despite its severity and chronic nature – he’s not one of your tame mentally ill; he’s a brilliant and positive person whom I find inspiring.

It was during the period that I was shooting test sequences for the film with “S” (to determine whether the people who would be in it could handle being in a film) that I discovered the secretive and unhelpful nature of the Central Sydney Area Health Service (CSAHS). I believe that this is relevant to your inquiry, as it appears to me that so long as the poor attitudes in the CSAHS remain, it will be difficult to make the changes needed for the patients.

Intending to make a positive film about an individual having a rich and fulfilling life despite the pain of mental illness, we needed to film – however carefully – at some of the mental health services facilities. So, I met to discuss the film with a doctor and a public relations person from CSAHS. At this meeting, we went through their protocols and, as agreed, I drew up an outline of how our filming might fit into these protocols and specified a time frame for filming. However, when I sent this proposal back to the person with whom I had discussed these fairly detailed arrangements, I received what seemed to be a highly anxious phone call from her, in effect saying that there had been no agreement for me to send this proposal and there was to be no filming on CSAHS property. Her agitated reaction surprised me greatly. I could only conclude that someone higher up had vetoed what we had agreed on – and rather vehemently, too. Subsequently, in discussing this incident with another experienced documentary maker, I learned that she had not long before been requested to make a film by a select committee looking into boarding houses in NSW but had had a similarly strong veto placed on her going anywhere near the CSAHS boarding houses and the film wasn’t made. I never received a written response to my letter and proposal from the CSAHS – only this rather strange phone call.

A similar veto came from the NSW Minister for Health, Craig Knowles, declining support or permission – very strongly—on the grounds – if I remember correctly – that his department thought such a film would violate the privacy of the mentally ill. Of course, this response would have emanated from consultation with the CSAHS and I began to wonder what the CSAHS thought they had to hide.

Ultimately, we did not make the final film. “S” began to feel differently about it and other things happened that led us to believe, despite a positive response from him and others to the test material, that a documentary would not be in his best interests. I may revive the project in a dramatised form, but if so, it would still be a positive story about people coping with mental illness and not an exposé of a system. In any case, it is not in anyone’s interest either to hide the problems in the mental health system or to attack those who are trying to deal with such a dysfunctional system. Rather we need to analyse what is wrong and try to address the problems in a positive way. Presumably this is what your committee is doing.

I would now like to make some observations about what I have seen over recent years, in relation to “S”, my daughter and others.

With regard to police, crisis teams and the community mental health centres: where there are long-term workers who are highly skilled, well-trained, well-administered, experienced and know the people they come into contact with, you couldn’t ask for better helpers. They are firm -- none of this wishy washy do-gooder stuff – dispassionate, kind and patient. They know when to say no and how and when to support and help. I have now met quite a few of these excellent health workers. My daughter was fortunate in being taken to the Newtown Police Station when she broke an AVO (she can be a bit scary, it’s true….) where the sergeant was terrific. I was there when he decided NOT to call the old dysfunctional crisis team we had dealt with before, but rather to get onto the crisis team from “Number 2” mental health centre. The nurse who came to the station was great – and luckily the sergeant was too, because it took four or five hours of my daughter being locked up until help arrived. Fortunately, I was allowed to sit near my daughter. I can only hope that the police who apprehended my daughter in the Byron Bay a couple of times were similarly kind as there she was entirely on her own until they took her to hospital.

Subsequently, my daughter has been treated by the same firm, experienced and knowledgeable “Number 2” Centre case-worker who visited her in the lock-up, a nurse who has been with the system for nearly 20 years and who has the patience of a saint – working with my daughter is pretty thankless as she often does not show up and does not always help herself or do what she agrees to do. For some time, “Number 2” Centre also had a couple of good doctors and my daughter stayed on her medicine even after the last court order to do so lapsed. The problem is, of course, is that she is not a priority. In Sydney, people like her can only see a doctor once every three or four months, even if they want the appointment. And if, as has been the case with my daughter recently, a mentally ill person does not really want an appointment, they continue to be administered pretty strong medicine with no check-ups (presumably, until they or a case-worker observes noticeable side effects). Someone as dysfunctional as my daughter seems not able to organise these check-ups for herself.

Another scarce resource for the mentally ill is therapy – some forms of which have been shown to be helpful. After some years, it was my daughter’s turn for therapy at the “Number 2” Centre but she didn’t (couldn’t?) get herself to the appointments and so the opportunity was lost. If you’re not ready at the right time, you miss out. Perhaps she didn’t miss much – everyone only gets a few sessions with the therapist, which may or may not be better than nothing. When I think what people with money or the ability to organise themselves get in the way of therapy, however, there’s a big difference. The worst off seem to get the least. I don’t want to see people locked up in hospitals again, but surely this is not what is meant by care in the community -- or by an equitable and civilised society.

The nature of the doctors and therapists themselves seems to make a difference in whether my daughter and others, who are so very sensitive, actually attend their appointments. If there is a doctor or therapist who is experienced and relates well to the patients, they are likely to attend appointments. This year there is a new doctor at “Number 2” Centre who doesn’t seem to have the same empathetic relationships with the patients as the old doctor – and certainly no time for carers. I got an almost angry response upon asking to see her. The old doctor however seemed to welcome the occasional consultation with me – just so long as my daughter was in the room and gave her permission. I haven’t seen the new doctor ever. And I don’t know why my daughter no longer sees her either (she missed her appointments, perhaps deliberately)…. and recently went off her medicine. Similarly, there are also some inexperienced and ineffective younger nurses who fill in when my daughter’s caseworker is away (which seems to be more frequently lately under the new regime at the centre). My daughter welcomes her regular caseworker, but not the others. Getting her to a GP is also very difficult, although at the moment she has physical complaints. Firmness, kindness but, above all, structure are what my daughter needs. And she can’t seem get it outside of hospital.

My daughter is actually one of the lucky ones who has been able to get into a hospital from time to time. Other people I know have to be in a really acute state to get there – and even then their stays are minimal because public hospitals have such limited numbers of beds. However, because I got private health insurance for my daughter before she became ill, and her father continues to pay for it, she has had about half a dozen voluntary admissions in Currumbin- Palm Beach Private Hospital, in Queensland (which she calls “rehab” as she is still in denial about having a mental illness). The hospital is a 12-step hospital which is equipped to deal with dual diagnosis. This is a rare thing. My daughter loves to go there, which she has now done once or even twice a year, and she improves markedly after each stay. At least for a while. The hospital now has told her, apparently, that she must function in the community, and that she can’t come back again – I think perhaps they don’t understand the lack of support for her in the community.

Living skills are a big issue for people like my daughter, as is therapy/social work to regain confidence and learn to work again. “S” told me that when he first was sick and in hospital (for six months!) many years ago, he had group therapy and when he got out, he attended a group run by one of the doctors from the hospital. He believes it was that group which set him up to survive. The network he formed through the group still offers mutual support to its members many years later. In that period also, there was a system of drop-in centres with a full range of programs as well as meals. One centre in our area (now closed) once had more than a dozen workers on staff. I am not sure how long ago this was – perhaps 15 or 20 years ago.

Ten years ago, when my daughter first became ill, I investigated these things. The Missenden Unit at RPA hospital had stopped all therapy. It was supposed to be a special treatment unit but now offered nothing except food, shelter and medicine -- for as short a time as possible. Beds are too scarce. I believe the same lack of therapy may exist right across the CSAHS mental health system – although I understand that there is some art therapy at Rozelle Hospital. During this time, the work unit (printing largely) at Rozelle hospital has been closed down, while the gardening work closed down a long time ago. The situation may be better in the wealthier areas. One of the things that shocked me shooting a film on a different health issue some years ago was the disparity in hospital facilities between rich and poor areas in NSW.

A further problem I have observed in public hospitals is a lack of appropriate staff, inadequate staffing numbers and stressful conditions for the staff.

Although there are some wonderful staff members, others can behave in cold and authoritarian ways towards patients for whom kindness is desperately important. (My daughter has benefited greatly from the kindness of staff at the private hospital). I have visited a fair few people in public hospital now and – yes, mentally ill people aren’t always the nicest people to deal with -- but I have been shocked by the unpleasant behaviour of some of the nurses – even when there is no provocation at all.

I have also been told by mental health nurses of widescale departures of experienced staff – but I have no way of checking what they say; it would be interesting to know staff retention rates. Apparently, there aren’t enough staff and enough resources and safety is an issue. Fear is an issue. “S” was jumped on, stripped and locked-up naked during a voluntary admission by a male nurse who was on the ward without enough support at night and who refused a request “S” made. This nurse reacted in a way that only provoked further trouble. This is not just what “S” told me, I attended the meeting “S” had with the hospital’s head nurse where the situation on the ward was discussed with admirable frankness. What was said during that meeting was that it is not always possible to recruit or keep appropriate staff. There are problems with staffing levels on the ward and therefore difficulty in granting what should be reasonable requests (in this case it was to be allowed to go to a smoking area at night when sleep was impossible). “S” ultimately received a written apology.

Along with the decline of therapeutic activities within the hospitals, the support that was once given outside by drop-in centres (where I first attended a family support group) have also been progressively shut down. I saw activities decrease over time until closure. Now – I believe – all that is left in our area are lunches at Marrickville – the meals being sausages and bread and salad – and perhaps not every day. The church lunches are better. But I understand that one of these has closed down too in the last couple of months.

While “S” and some other people manage to live on the pension, other mentally ill people I know, including my daughter, cannot manage their very meagre resources well enough to get through the two weeks and these lunches are essential. Some people just aren’t capable of cooking for themselves. This need for meals exists for people who live in public housing as well as on the street and in rented rooms. Some people pay almost all their pension money for rooms you wouldn’t put a dog in (there is a sequence in the film I made with “S” which shows typical conditions in such rooms, if you care to see it.) It is not clear to me what help with money-management is given by the mental health centres, but it is an important issue.

In my experience, housing is one of the single biggest issues faced by people with mental illness. First of all, you have to be able to get into the housing system and that’s dependent on your consistent attendance at an understaffed mental health centre which is not going to chase you. Then too, the boarding and half-way houses I have seen vary greatly in quality. I really wouldn’t want my daughter to live in some of them. Others are okay. Public housing can be good as well as not too good, and I know about a dozen mentally ill people who have gotten priority public housing in their own communities – some of it very good. But if there are complaints about them or they don’t manage their money and pay their rent, they have to go and for a couple of people I know this has been a disaster – they haven’t gone into the system but out into expensive slum rooms. Recently, my daughter was given a bed-sitter in a block of 12 transitional flats for people with mental illness. I think this block is the first and, given available resources, likely to be the only facility of its kind for a long time. It’s in a good area for her and is in good condition and affordable ($70/week including electricity, fridge and washing machine) but she hates being on a busy road and feels too isolated. She will soon move on to housing commission, but the housing officer has told her that if there are complaints about her screaming (which she still does), she will be put out. She does not want to go to a boarding house or a half-way house and wouldn’t stay if she were put there. What she needs is a self-contained flatette in a co-op with some shared common rooms and facilities and a caseworker to stop in every week just to check. She needs trees around her and tranquillity….and to belong somewhere. She wants to come home but, although I miss her, that’s a backward step for her right now.

My daughter worked from the age of 13 to 22 and she wants a job. She needs the money; she needs the self-respect. She doesn’t manage well on $200+ a week – and recently both transport and the cost of her medicine have increased without a corresponding increase in the pension. She is not sufficiently stable, presentable or organised enough for an ordinary job – and when she investigated the so-called sheltered workshops (privately owned) – which to her credit she did – she found that they paid virtually slave wages – I can’t remember the amount precisely now but it was so low that it was hard to believe. She wasn’t well enough to benefit from the Commonwealth Rehabilitation Service, unfortunately, although I found that it existed and she tried attending. (The different government ervices don’t seem to be well coordinated and I found this one almost by accident….) She needs a highly structured situation and can’t provide it for herself. She often can’t get up in the morning to get where she is going.

Not all people with mental illness are isolated but the majority of those I know are very isolated and have little to do. They try different things – educational courses are good, but they can’t always maintain their attendance. And I have heard that the fee waiver at TAFE for people on disability pensions is going to be discontinued. I know three people who have benches where they sit regularly day in and day out and get to know the passers-by in the neighbourhood. My daughter couldn’t do that. For a while she went to a private drop-in centre, from time to time, but she rejected being with the floridly mentally ill and the zombie people there and stopped going. It is also not in her immediate neighbourhood. She sometimes volunteers at the church up the street where she gets her lunches; she tries to be regular once a week but she doesn’t always make it. She blames herself when she fails to do what she ought to do and that only makes things worse. Sometimes she goes to church services and Buddhist talks. She goes to 12 step meetings for her eating disorder – they are the best thing in her life. She sometimes talks to the girl in the next flat, but I don’t think that it is a friendship which will continue once they both move on into regular public housing.

My daughter was a girl who was once artistic and so intelligent that she could have gone to medical school on her humanities HSC results. Her high school photographs were hung in the Art Express at the Art Gallery of NSW; her poetry was brilliant. She was kind to little children. She was never out-going but lived with other people and participated in life. She travelled. She would go out to get a job and always return with one. She was a capable person. Now she’s not very capable at all; her parents are getting old and I am fearful -- especially with the new federal legislation aimed at getting people off the pension – of what will become of her. She already lives in poverty – even with parents who try to help her. Care in the community needs to become a much greater reality for my daughter and others in her situation.

I think it is true that we can measure a society by the support it gives those least able to care for themselves. By that standard, Australia has become uncaring, even cruel. The rich are getting richer and the poor will be getting even poorer over the next few years – and not just in material terms. In reality, given the shared philosophy of both major political parties, what difference will this select committee inquiry actually make? Even if some good recommendations come out of it, do the politicians have the political will to ensure their implementation? Caring for the mentally ill must be above party-politics and petty point-scoring. I hope that this time this inquiry will make a real difference.