NATIONAL COUNCIL OF WOMEN OF AUSTRALIA Inc Ltd
Affiliated with the International Council of Women

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28 May 2005

Kelly Paxman
Principal Research Officer
Senate Select Committee on Mental Health
Parliament House
CANBERRA ACT 2600

Dear Kelly,

On behalf of the National Council of Women of Australia Inc Ltd, I write to thank you for the extension of time for our submission.

Representatives from every state council attended our Mid Term conference held in Canberra19-22 May 2005. Three State Councils had combined to present a resolution on Mental Health which indicates the concern in the community for this matter.

We also heard Senator Gary Humphries of ACT speak on 'Australia - a picture of mental health? We were dismayed to hear that in 10 years the proportion of persons affected each year with a mental condition had risen from 5% to 10%.

Our submission is enclosed.

Once again, thank you for the extension.

Kind regards,

Leonie Christopherson
President.

Submission to the Senate Inquiry into Mental Health Services from the National Council of Women of Australia Inc Ltd
May 2005.

The National Council of Women of Australia (NCWA) first met in Sydney, NSW in 1896. An umbrella organisation, through its affilates, it addresses all issues of concern to women and their families. NCWA's seven Constituent State Councils meet each month and provide an avenue of action for all women. The State Councils can advocate State Governments and the National body advocates the Federal Government and through its membership of the International Council of Women speaks for Australia on international issues. Affectionately nick-named 'Stirrers with Style' the members of their standing committees in Communication, General Well-Being, Social Issues, Status of Women and Sustainable Development voluntarily utilise their professional expertise to undertake research and disseminate information.

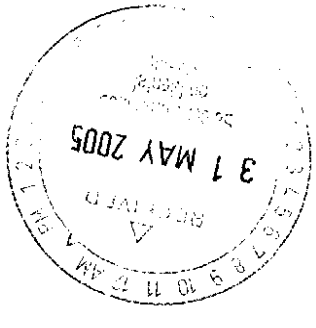
NCWA would like to take this opportunity to congratulate the Government on the founding of the National Depression Initiative in establishing beyondblue in Melbourne. Its name and cheerful butterfly logo have done a great deal to remove the stigma of mental illness. There is also an excellent video on depression by actor John Cleese provided by one of the drug companies. Could we see more of the same 'happier and less doom-and-gloom approach' nationwide?

At their Mid-Term Conference held in Canberra from 19-22 May 2005, delegates travelled at their own expense from all over Australia to debate over 20 resolutions ranging in subjects from the Murray Darling Basin, the morning after pill to mental health. Before debating our resolution of mental health the conference was addressed by Senator Gary Humphries of ACT. An extract from the Minutes follows:

PRESENTATION
Senator Gary Humphries was welcomed by Chair. Senator Humphries spoke on 'Australia – A Picture of Mental Health?'

Discussion Points
Senator Humphries agreed to follow up on the following items:

- Request that the prevalence of depression amongst Korean War veterans be included in the current Senate Select Commission.
- Because depression and suicide is prevalent in Indigenous communities it was requested that trained indigenous representatives be members of the current Senate Select Commission. Would be acted on once evidence was provided to the Committee.
- Research has almost proved that marijuana is linked to schizophrenia – especially if used by Under 16 years.
- People with a mental problem want to be off day treatment and want to be employed. Question: Had the Senate Select Committee received a copy of the presentation by Professor Bond – 'Supported Employment'.?



The following resolution was carried unanimously:

RESOLUTION 12 – MENTAL HEALTH FUNDING
Submitted by NCWs SA, CTI, ACT

THAT this Conference of NCWA urges the Federal and State Governments to implement immediate action to increase the funding allocation for Mental Health to a level reflecting the extent to which mental health problems have been shown to affect the population, in order to provide essential supportive policies which include the following:

- appropriate supervised accommodation on hospital discharge
- community housing with appropriate services
- respite facilities for both carers and sufferers
- appropriate training for service providers
- continuation of education programs to reduce stigma
- early intervention programs for young people suffering mental illness
- innovative workplace employment schemes

This requires a coordinated approach between State and Federal Governments, service providers, NGOs and other community groups.

Moved: B. Pavey **Seconded:** C.Fleming
CARRIED
For: 97 **Against**: 0 **Abstention**:0

Discussion Points

- Mental Health in Australia is tragic – Report will detail certain Human Rights violations.
- National Rural Coalition noted at their Conference the impact on mental illness in Rural areas and the effect on women.
- AMA given a submission to the current Senate Inquiry
- Appropriate time for NCWA to be submitting this Resolution.

(Close of extract from Minutes.)

Anecdotal Evidence.

One of our members is the prime carer of her 33 year old schizophrenic son. He has tried living on his own without success. He must have constant supervision to ensure he takes his prescribed medication. Her concern is what will happen as she ages and will no longer be there to supervise him. She suggests that supervised community care be available to all those who need it and respite care for full time carers such as herself. We

respect her judgement and think you may find her clear and frank answers to the following questions of value to the Committee. She also has the rare honesty to say when she does not know an answer.

1. The extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress;

Mental Health is still not seen as an important issue. I get the feeling patients (who are sick remember) are thought of little better than criminals. Some have even become so in fact, either because they were unmedicated or because they see prison as somewhere they will be cared for.

2. The adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;

Different parts of Australia will probably produce different experiences. I understand Queensland has the lowest spending on Mental Health in Australia.

I still hear stories of parents taking their obviously very sick adult children to the Psychiatric Hospitals only to be told there are no beds, or they are not sick enough to be admitted. Do you really think any parent would take their child to a mental hospital if they weren't so sick the parent felt unable to cope with it any longer, or even were in fear of their own safety?

3. Opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;

After hours crisis services are very rare, and not easy to access. Some refuse to come unless the patient calls them. Can you think of anything more useless.

Prevention would include an advertising campaign highlighting the major part that Marijuana has played in the mental health problems of a large number of those who now are diagnosed as having Schizophrenia.

Early Intervention would require many more professional people in schools to pick up on early signs of distress. Many psychiatric patients start their sickness while still at school, (from smoking Marijuana) and not enough is done to help them or their families.

Community Care:- I am sure this exists but I haven't seen any.

Respite Care:- There are only two places in Brisbane that I know of. One North and one South., and they are for ARAFMI members only.

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

I don't know enough about what happens already to comment.

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

Answered previously.

6. The special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;

Special needs of children:- It is a major shock, when a child becomes diagnosed with a mental health problem in a family where none has previously been known. When your child is suddenly locked up you do not know what to do, or who to ask for help.

If I had to do it again, I would insist on being locked up with my child as well. The parents of sick children are allowed to stay with them in hospital, why not the parents of ALL children. He was only 15 and very scared, and I didn't get a chance to help him.

Even when your child reaches the age of 18, you are still their parent, and still involved in their care if they are sick. Manic Depression and Schizophrenia are diseases, that require special skills and information. It is very distressing to be told by the doctor that they are adults now, and you have no input into their care, and they (the doctors) do not want to talk to you. How can they know what is happening at home? The patient is not going to tell them. As far as *they* are concerned there is nothing wrong with *them*. I have not had this problem very often, but I know many people who have.

Special needs of Rural patients:- In a big city it is easy to hide if you want to. In a country town that is impossible. It is impossible to go to a local doctor without the whole town knowing, so patients are even more reluctant to seek treatment. Parents feel isolated as well, and become unable to maintain social relationships. I understand from speaking to people who live in Longreach that their chances of finding accommodation or care near their home is very slight.

Drug and alcohol dependence:- It may seem logical to say, 'we can't do anything for you until you recover from these', but treating the mental problem will go a long way to remove the need for the dependencies. Why should they be denied treatment for one disease because they have a second, when what they really need it treatment for both?

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

Answered previously.

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

Who is responsible for '**Primary Health Care**' If you mean doctors, some do and others don't, but I have not heard of any facilities for Chronic Care management. That doesn't mean they don't exist, just I don't know where, and if I don't know where nor would a lot of other people.

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

Most medications have side affects. Some are more severe than others. In general the older ones we were prescribed caused Tardive Dyskenesia and drowsiness, and many of the newer ones cause excessive weight gain, with the drowsiness.. This weight gain can be so severe that patients stop taking the medication because of it. What can be done about that I am not sure.

10. The overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people;

If there were more suitable supported accommodation for patients, there would be no need for them to find ways of going into and then staying in prisons for a roof and meals and even some occupation. Not all patients see it as an option, but they are the ones who have family able to look after them.

Some offend because they have gone off the medication, and are not in control of their actions. Their hallucinations and voices are very real. If the voices say "You have to go and do so and so,", they are very likely to do just that. Our son jumped off a bridge because the voices told him to., "Stupid voices, they should have waited until the tide came in" He smashed both his heels, and broke a bone in one leg. While he was till in a wheel chair from that they told him to do it again. So he wheeled himself to the Indooroopilly bridge (we lived about a kilometre away) and jumped. He managed to drag himself out of the river, but he had broken the leg again.

I can't speak on the effect being in prison might have on a person, but I know Andrew attempted suicide twice, because he believed (another delusion) that the police were looking for him to put him in jail, and he would rather die.

11. The practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion;

It may seem a denial of a patient's rights to keep them in a secure facility, but they also have the right to be kept safe. Our son has been in a locked ward many times, and that is the only time I felt confident that he was being looked after. I have lost count of the number of times the hospital rang us up, and said "we have lost Andrew", when he was not in the secure ward (he even went missing in his wheel chair) If he had been being cared for properly he would not have jumped off that first bridge, as he was actually in Hospital at the time, having his medication fine tuned. (He was not found for 26 hours by which time his feet were badly infected, and he came close to losing one.)

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

Most of the information provided to relatives comes from the support groups. eg Association for the Relatives and Friends of the Mentally Ill. (ARAFMI). There is a long way to go before mental illness will be an acceptable illness.

13. The proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness;

We (The National Council of Women of Qld) have been trying to get our Ministers for Health and Housing to enter into meaningful dialogue with us, re the provision of Supported Accommodation for patients who are well enough to be in the community, but still not up to being completely responsible for themselves. The major support that is needed in to make sure they are taking their medication. If that breaks down, it is a very quick trip back to hospital, and then the rented accommodation they are in is lost to them and they have to start again finding new accommodation, when they are discharged.. If they are lucky to have relatives of friends to rescue their belongings while they are in hospital, they are better off than those who do not, and often lose all their belongings and have to start again, from scratch.

Some also need a little help with budgeting.

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

. Many pieces of research that were done in America in the 1980's are still not accepted here, as being relevant. eg. I have a number of papers testing the hypothesis that some Psychiatric patients could be reacting to Gluten When I mentioned this to Andrew's doctors in 1988, I was told it was a lot of nonsense, and if I didn't approve of the

treatment he was receiving I was welcome to take him home again. This was beyond us so we had to let it drop. In about 1994 I found a GP who also believed this, and we experimented with it. He was much better, and even went looking for Gluten Free pasta of his own accord, but when he broke the diet he ended up back in hospital. At this point the hospital doctors again said it wasn't possible, so Andrew believed them and didn't go back on it. We have tried it once more, and again, he was much better, but he now says, "he would rather take the medication, than go without bread"

I know some of the current research coming from America advocates taking lots of vitamins, but he has lost faith in any other treatment, and isn't even willing to take a multi vitamin to supplement his diet, and overcome some of the effects of heavy smoking.

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

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

Unable to comment on 15 and 16.

National Council of Women of Australia is grateful to the member for her answers above.

Senile Dementia and Alzheimers Disease

Other members have highlighted the increasing need for pleasant secured residential care for elderly family members who suffer from senile dementia or Alzheimer's Disease. While some older facilities have still have prison-like security systems, we applaud the introduction of discreet electronic numbered keypad locks and the use of attractive higher trellis fences in surrounding courtyards and gardens to ensure the safety of the patients who are inclined to wander. We would like to see more of the same available.

This submission has been authorised by
Leonie Christopherson,
President of the National Council of Women of Australia Inc Ltd.

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