Submission to the Senate Select Committee into Mental Health Services

By

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June 2005

NB the following points relate to the Terms of Reference given by the Committee and only some will be addressed.

a) Separate State & Territory Mental Health Acts mean that the National Mental Health Strategy standards have little sanction.

In addition, the separate Acts require more coordination (than would a single Act) when the client is geographically mobile. This coordination is not happening sufficiently at present.

The temporary project driven funding provided under the NMHS means that essential innovative and well developed activities may not find permanent funding and so ongoing service is not possible.

b) Personality disorders are not currently classed as 'mental illness'. A conservative reliance upon such narrow definitions of mental illness, means that much needed psychiatric activities for personality disorder will not attract funding.

In order to protect our next generations, our society desperately needs to have several coordinated approaches to intervening in parental personality disorder in order to lessen the potential for social generation of personality disorder and mental illness in children.

The needs of children with parental mental illness are beginning to be recognized but this aspect needs to become part of routine care. Provision of services within the home, including mentoring, role modeling, parenting skills etc are known to prevent longer term intergenerational mental health and other welfare problems in the children. Subsets of the next generation is seriously at risk if we do not act now.

In some instances of strong inheritance of mental illness, genetic counseling may be useful.

Most of the nation's mental health activity is still in the acute sector due to inadequate funding and staffing so that there is a palpable lack of early intervention and prevention activities. Those that exist are frequently funded temporarily under project funding. Early intervention and health promotion need to be funded appropriately in an ongoing manner and the need will never go away.

In Tasmania there are only 8 high acute beds for the state! Bedlock frequently occurs, and now the state has to buy beds in the private sector (much to some patients' satisfaction). A similar number of beds exist for planned respite. Some of this may be addressed in the current state review *Bridging the Gap*, however the state has only funded half the amount suggested by the original committee.

c) In addition to point a) above, there still exist barriers to wholistic intervention. We hear talk of whole of government response but it is only rhetoric. Interdepartmental barriers of 'not our responsibility', incompatible philosophies of intervention (eg. between drug and alcohol and mental health) and including over-broad concepts of confidentiality. To achieve the ideal of whole-of-

government response to a whole-of-person need, we need to also train staff in multiple disciplines in mental health and refer intricacies to specialists in a multi-disciplinary team.

f) **Early intervention services for children and adolescents in Tasmania are seriously inadequate. Referrals from school-based personnel (psychologists and social workers as well as teachers) of young people who are in need of intervention are rarely able to be acted upon by Children and Adolescent Mental Health Services because of over-burdened services and un-coordinated service delivery.**

A case-management approach, with input from key players in young people's lives across different government and non-government agencies, is rarely implemented because of the paucity of options for intervention and support available in the community.

Young people in the care of the State and those with disabilities (particularly autism spectrum disorder), for whom case-management is critical, are particularly vulnerable under the current inadequate service delivery arrangements.

g) This aspect is suitable for peer support agencies to run, so the existing ARAFMIs and Mental Illness Fellowships etc should be suitably funded to provide information, support, skills and training for significant others.

There is a duty of care to enable supportive persons to provide oversight of dangerous treatment side effects, & have a conduit of effective therapeutic communication with the treating team, indeed to be included as part of the treating team. Privacy Acts are often interpreted too broadly to mean that the clinician never listens to the supporter and thus loses essential clinical information to the case.

h) General or primary health sectors may act as initial point of contact. The *Better Outcomes in Mental Health* initiative is useful but does not go far enough in terms of the number of sessions a person may have with Medicare psychology or allied health services. In addition it is usually too much to expect an unwell person to doctor shop to find a GP who is participating in this initiative. The current limited time session offered by GPs is also not conducive to offering an assessment for an unwell person who may not have the wherewithal to ask for an extended consult (and even that is too short a time).

i) At varying levels of training and in-service development there can be opportunities for support persons/ families and consumers to offer their experience in the generation of appropriate attitudes towards individuals and their families.

j) Appropriate therapeutic interventions need to be provided for persons who have mental illness while in prison. In addition where a person has offended and this offense has been partly caused by the illness, or while the person **is** unwell, such a person must receive appropriate mandatory mental health intervention as a matter of human rights (although the person may not have the insight to recognise this at the time).

k) Managers of detention & justice facilities need to be kept abreast of up to date international best practice on the issues of seclusion and its prevention for disordered behaviour. Sanctions would need to be applied to facilities **which** breach principles of best practice, human rights and humane treatment.

l) Schools are key sites for the development of inclusive and informed societies. Whilst the Australian Government has supported the development and implementation of the *MindMatters* program in secondary schools, sustained support for the program needs to be guaranteed into the future.

The introduction of appropriate awareness and support programs in the primary years is critical for students, families and the broader community, as are ongoing drug and alcohol education programs in primary and secondary schools.

The effectiveness of education programs will be enhanced in communities where across-agency approaches are adopted. Resources should be provided for good-practice, community-based collaborative models to be identified and replicated.

m) As mentioned above, there needs to be several workers in each department who would have some mental health training in order to respond more effectively to clients with welfare needs. In-service updates need to be attended to in order to keep up with latest research findings. Interdepartmental and interagency cooperation to provide seamless care is necessary.

p) Tasmania's dispersed and relatively low population makes services to rural areas very difficult. Improved access to support and intervention through new technologies is essential for families and carers in rural and isolated areas of Tasmania. Further development of electronic services for this purpose is encouraged, especially within a coordinated case-management model.