Committee Secretary
Senate Select Committee on Mental Health
Department of the Senate
Parliament House
Canberra ACT 2600

23/5/05

Dear Sir,

I wish to make a submission to the Senate Select Committee Inquiry into Mental Health. Although the closing date has passed, I have been encouraged to make this submission by Senator Allison. I am a psychiatrist in private practice in Sydney and hold the following positions:

Associate Director of the Mood Disorders Unit, Northside Clinic, Sydney;
Clinical Lecturer, Department of Psychological Medicine, University of Sydney;
Director of Electroconvulsive Therapy Services, Ramsay Sydney Hospitals;
Director, ECT Training Programme, Northside Clinic;
Chairman, Committee for Psychotropic Drugs and Other Physical Treatments, Royal Australian and New Zealand College of Psychiatrists.

I make this submission as a private citizen, not as a representative of any of the above organizations. My submission addresses the following term of reference of the inquiry:

b. 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.

1. As a private psychiatrist I have been aware for some time of practices occurring in NSW public hospitals which I believe indicate inadequate or inappropriate care of acutely mentally ill patients.
a) A major concern is that it is common practice for patients who have been detained under the NSW Mental Health Act (involuntary patients) to be held in the Accident and Emergency Centres of public hospitals for several days at a time because of the lack of availability of acute beds in psychiatric hospitals. These patients are actually guarded by security guards who have no psychiatric training and no appropriate psychiatric care is provided. I have interviewed patients who have been through this experience and my younger colleagues who work as registrars in the public system tell me that this is now standard practice. I have no knowledge of what instructions (with particular reference to physical restraint) may be given to the untrained security staff in the case of a patient attempting to abscond or cause harm to themselves or others. I have been told that usually there are no trained psychiatric staff available to care for these patients. It seems to me that as well as being unacceptable management of acutely psychotic or suicidal patients, this practice may not comply with the current Act.
I understand that there is some interest in the establishment of acute emergency services for psychiatric patients within existing Accident and Emergency Centres. I cannot comment on the relative merits of this proposed development, but it is a

separate issue to the situation I have described above.

b) The lack of acute beds means that the situation often arises where a detained patient is sent to any hospital in the state where a bed may be available. This may be in a rural centre, hundreds of kilometres from the patient's home, family and support system. Registrars can spend hours ringing around the state trying to find a bed and if unsuccessful, then the option of being held in the A&E centre under guard is taken. Transfer of the patient, including long-distance transfer, always involves ambulance and often police services.

c) The pressure of bed availability means that patients are discharged rapidly, before they are really ready in order to make way for more acutely disturbed patients. Apart from the impact on the patient's illness of premature discharge, including any risk to self or others, the registrars and psychiatrists have the unenviable task of discharging patients whom they know are not well enough. This is one of the factors which is leading to widespread demoralisation of mental health workers and the subsequent avoidance of choosing psychiatry as a career.

I do not work in the public system, so my comments are based on hearsay, but I hear of these situations repeatedly and my own patients have had these experiences.

2. Over the last 12 years I have been extensively involved in the training of psychiatrists, registrars and medical officers in the provision of electroconvulsive therapy. I have also been instrumental in developing the RANZCP guidelines for ECT and have edited, with Professor John Tiller, a small textbook on ECT which was launched in 2003 by the previous Minister for Health, Senator Kay Patterson. ECT remains one of the most important and effective treatments in psychiatry and modern, safe, effective ECT should be available to all psychiatric patients who require this treatment. ECT continues to play an important role in the treatment of medication resistant depression as well as certain other conditions and at times the treatment is life saving. There have been many developments in the practice of ECT which have resulted in major changes to technique with improved outcomes, particularly with respect to unwanted side effects such as memory effects. These changes have meant that administering ECT has become a “subspecialty” and appropriate training and supervision of both trainee practitioners and ECT services within hospitals is now necessary.

In the past ECT was commonly given by the most junior psychiatry registrars, very often with no instruction and with no supervision. This situation has fortunately been largely addressed through the establishment of active, comprehensive training programmes at private psychiatric clinics in Melbourne and Sydney which have provided training for several hundred practitioners over the last decade.

The RANZCP now requires all trainees to be adequately trained in the provision of ECT. While this is a welcome initiative by the College it is not expected that such basic training would equip registrars or psychiatrists to administer ECT without further training and ongoing supervision.

I believe that there remain deficiencies in ECT services which require attention. As well as providing training in Sydney, through which I learn much of the standard of ECT practice in NSW and other states, I sometimes travel to a small number of regional centres to provide on-site training for medical and nursing staff. I have the following concerns about the adequacy of ECT services in a number of centres.

a) I am aware that ECT is not provided in some centres, even at some acute admission centres in major teaching hospitals. In some other centres the hospital will provide ECT only to a limited number of patients at any one time. These limitations are imposed by the availability of theatre and anaesthetic services. ECT tends to be given a low priority compared to other theatre cases and anaesthetists and theatre staff do not always understand the importance of the treatment. I believe that negative attitudes to ECT and possibly the stigma associated with mental illness can play a role in this. In other settings, i.e. private and public psychiatric units that are not associated with a general hospital, it can be difficult to obtain regular anaesthetic services for ECT.

b) It still occurs, even at some major hospitals, that ECT practitioners do not receive adequate training and supervision before being required to give ECT treatments. This is most likely to occur if the hospital does not have a designated psychiatrist whose task it is to provide training and supervision.

c) Hospitals (at least in NSW) often do not have a Director of ECT Services. This then leads to the situation described above, with the end result that psychiatrists lose confidence in the service and ECT is not prescribed when it should.

It is my belief that unless an ECT service is properly organized and maintained and adequate training and supervision are provided, then patient care is compromised. This occurs either because substandard ECT is being provided or because an ECT service is not provided at all or is under-utilized. My observation is that such well organized ECT services are relatively uncommon in public hospitals. These are the very centres which treat those patients who are likely to have the greatest need for ECT. In my opinion, to address these deficiencies there needs to be an increased effort by mental health services to appoint appropriate directors of ECT services and to provide adequate local training and supervision of ECT practitioners and nursing staff. Directors might be responsible for a single service or may be regionally based to supervise several services. In either case it is important that sufficient hours are allocated for the task and that responsibility for ECT services is not simply added to a list of the other duties of a staff specialist psychiatrist who may then not have the time or interest to adequately oversee the service. I would see this as being a basic first step to improve and maintain standards and ensure adequate access for all patients to this important treatment.

Thank you for the opportunity of making this brief submission to the Inquiry.

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