16/06/05

ReSubmission To Senate Committee on Mental Health

Preamble.

A carer's experience.

This submission is an anecdotal account of my experience of seeking treatment for my son's schizophrenic condition from 1999 to 2005. The outcomes I hope to achieve by this submission are an increased awareness of the horror of mental illness when it occurs in a member of ones own family, having the characteristics of a never ending car accident, and the impossibility of managing a person with a mental illness given the intervention resistant culture shown by Mental Health Services in regard to the responsible treatment of mental illness. This lack of appropriate intervention has led to my son's imprisonment as a result of a near fatal stabbing. This submission is a testament to the unfair burden of care that is placed on the mentally ill to care for themselves and as a consequence the families of those with mental illness. I have also included my thoughts and ideas for what they are worth as a basis for further discussion of what steps need to be taken to improve the treatment of the mentally ill and their carers and families.

Sincerely

The experience of mental illness.

In December 2003 my son now aged 23 attacked a neighbour who was socializing with him, my son has stated the reason for the attack was because he wished to prevent the neighbour from going home at dawn after he had spent the night in my son's company. It was nearly fatal assault and was a predictable outcome given the lack coherent policy and administration in mental health services. This happened after I had moved my family to QLD from Victoria where my son was on a community treatment order for biweekly compulsory medication. A major contributing reason for the stabbing was the discontinuance by QLD Mental Health of the compulsory medication status. The move also resulted in the dismantling of all previously existing psychiatric management structures for my son when he decided to return to Victoria. Although there are better agreements between states now in regard to community treatment orders the general culture of resisting intervention and lack of responsive facilities remains the same.

My son has been admitted to Psychiatric hospitals 18 or so times following his first admission in March1999 each admission normally involves a number of failed attempts at gaining admission after violent behaviour physical assaults and property destruction.

The repeated problems encountered have been of a relatively simple nature although it has been difficult to implement solutions within the existing legal framework. The biggest problem is failure to identify and treat levels of psychosis that would be likely respond to available medications, failure to provide accommodation and appropriate physical and legal constraints to prevent behaviours such as substance abuse in the patient that would aggravate their illness but if these constraints were applied would facilitate social reintegration.

The 18 or relapses and hospitalizations my son has experienced have prevented him from continuing a vocation and developing life and social skills. As a result there has been little chance of my son getting beyond efforts at stabilising the physiological aspects of his illness and moving on to dealing with cognitive aspects of his illness and psycho social rehabilitation such as the development of a vocation and some semblance of normative social life.

History of admissions

In 1998 my son exhibited paranoia violent outbursts and sometimes bizarre behaviour which led to him leaving the boarding school he was attending prior to the end of year 11 and commencing an apprenticeship with a house framing company he had been working for on a part time basis for the preceding 18 months. School councillors and psychologists, alternative medicine practitioners consulted never mentioned and seemed unaware we might be dealing with the onset of serious mental illness in spite of the fact my son was at the normal age of onset for males. The trained psychologists I consulted had no experience of clinical mental illness and were unable to recognise scenarios that someone with experience would easily recognise suggest a serious psychosis needing physiological intervention (antipsychotic medication).

1999 March-April Maroondah hospital adolescent unit

The police helicopter had to land on the Burwood Highway Melbourne during peak hour traffic as my son was wandering in traffic and believed he could teleport. In the months preceding his behaviour had been bizarre and erratic. At this time a contributing factor was most likely persistent drug (marijuana) use and this admission was considered a drug induced psychosis. While hospitalized the acute psychosis persisted for a month or so with obvious florid symptoms like hearing voices, believing he could control the weather and prior to admission thinking he had been able to control time.

1999 December –March 2000

During the period after his first admission my son stayed for several months in his darkened bedroom refusing all contact and medication. I was told by his case manager my son was experiencing post psychotic depression. I attempted to have my son treated by a private psychiatrist but after an initial visit with my son the psychiatrist said he would not treat my son as he was too ill, was unco-operative and needed long term institutional care and rehabilitation but he said there were no existent facilities he could be referred to. A fascination with knives and weapons was apparent and most of our knives disappeared from the kitchen, some of which were later found embedded in my sons bedroom walls.

1999 November

My son had remained in his bedroom for several months since his release in April 1999. In November he started leaving the house and during that month he seemed to be on the move 24 hours a day and he had refused most forms of therapeutic treatment or medication during the whole period but no decisive action was taken by his case manager who visited on a weekly basis and insisted my son doing well until the case manager ceased visiting in November because my son turned 18 and was no longer catered for by this service.

1999 December
When he was again admitted to Maroondah Hospital psych ward my son had a 3 week old untreated fractured leg gained after clinging onto and being thrown from a car; he was taken to William Englis hospital emergency ward after the incident but would not remain stationary for long enough for the cast to be applied. There were several prior attempts seeking admission over preceding months mainly due to violent and abusive behaviour.
During this stay in Maroondah hospital my son broke another patients arm.

2000 March
I ceased my profession in computing in order to focus on strategies that might assist with my son's rehabilitation. I had been resisting taking my son back into my care seeing the need for independent accommodation in a residential rehabilitative environment.
My son was released into his mother's custody in spite of my protestations even though it was known that she has always encouraged my son to use marijuana and after a few weeks he returned to my custody. In May we travelled to QLD on route to NT where I intended to stay with a male friend for an extended period in an isolated community and gauge the extent to which freedom from marijuana improved my son's illness and because I needed the assistance of another man who was not easily intimidated to help manage my son's behaviour. My son seemed to be only occasionally accepting of oral medication if given.

2000 June
We travelled to Queensland en routs to NT in order that my son be present at a special ritual performed by a highly qualified Tibetan Lama at a Tibetan Institute. While still in QLD my son had been resisting taking oral medication and pretty much to make a point about my harassing him to take it he attempted suicide, taking an overdose of his medication. I had left him alone to go shopping but his behaviour had been a bit unusual so I returned and found him unconscious having taken 76 10mg Olanzapine tablets, three months supply. He was admitted to Nambour Hospital intensive care unit and transferred to Ipswich for about a week. When he returned to the institute my son attended the ritual. I did not attend but there was a noticeable effect, for the remainder of the day for the first time since the onset of his illness, I felt as though the loving son I had once known had returned. Unfortunately by the next morning things returned to how they were before the ritual.

Also in June my son was again admitted to Nambour hospital after he became violent at Mudjimba beach Sunshine Coast but released after a couple of days.

2000 July
We travelled to a friend's house 100km south of Uluru NT and spent 3 months in the isolation of a Central Australian aboriginal homeland at Alpara NT. This action limited marijuana use but I found that he was now only occasionally compliant with the oral medication, respiridal. He was generally unmanageable as he was constantly abusive to me and displayed violent behaviour, high levels of anxiety and he had persistent unreasonable beliefs.

2000 September
We travelled to Alice Springs to get the car radiator fixed; My son was admitted to Alice Springs hospital for observation having become violent when drunk while in Alice Springs Caravan Park. As a retribution for restraining him in the caravan park prior to his admission my son clubbed me with a 4 inch diameter branch breaking it across my back on the way back to Alpara, when we camped overnight at a saltpan about 500km south of Alice Springs.

2000 November
I grew tired of being alone with my son when my friend went to work. my son's mental state seemed to be deteriorating at Alpara and assaults were becoming more frequent. After leaving we drove straight through from Ayers rock to Melbourne with my son screaming at me most of the way and he assaulted me when I chose to drink some water with the "perfect" McDonalds meal he had purchased for me when we finally stopped to eat at Horsham. On returning to Melbourne my son wished to stay with his mother for a while and within 2 weeks was admitted to Maroondah hospital for couple of weeks in the Maroondah psychiatric ward, having presented with a severely cut hand, after which he was again released into my custody, without much actual change in his condition.

2000 December
My son was removed from my Ferntree Gully home brandishing (rather theatrically), a makeshift bow and arrow made from a car sun visor and a bandage which the ambulance drivers generously construed as a weapon. He demonstrated inappropriate conversation, had been abusive to family and neighbours and he was admitted to Maroondah Hospital psychiatric unit again.

14/12/2000
Restraining orders were initiated at Ringwood Magistrates court against my son by both parents preventing his release from Maroondah Hospital to either parent. This was a rare piece of co-operation between my son' mother and me and was designed to facilitate placement in some sort of long term rehabilitative facility.

2001 May
At the end of a long stay in Maroondah hospital after much agitation from me, my son was released for the first time with a considered rehabilitative strategy facilitated in part by the treating psychiatrist. My son was offered a place in Schizophrenic Fellowship accommodation in Richmond. State Trusties had been given authority to manage my son's disability pension and my son was placed on a Community Treatment Order (CTO) of 100 to 150 mg of Zucholpenthixal Biweekly by Mental health Services Vic. My son complied with the order that required him to present himself to Clarendon Clinic East Melbourne bi-weekly for depot medication. A social support worker from the SFV (Schizophrenic Fellowship Vic, now Mental Health Fellowship) visited my son once a week or so.

Things seemed to be going well for a month or so there was a significant improvement in my son's abilities under the CTO. In November 2001 he took driving lessons and obtained a Victorian drivers licence. This improvement demonstrated to me that for the previous 2 years ,due to the lack of a CTO, I had been required by

Mental Health Services to care for a person who was treatment resistant and had demonstrable psychotic attributes the whole time, due to being more of less completely unmedicated except while in psychiatric care.

During this period in a SFV shared townhouse although medicated my son was completely unsupervised most of the time and showed an inability to abide by the rules of his accommodation. He did not abstain from marijuana and alcohol use and did not prohibit 2 friends and his 1/2 sibling sister from residing with him. My son and his friends extensively damaged the flat and intimidated his other SFV client flat mate. Other than eviction Schizophrenic Society and Mental Health Services had no control mechanisms in place to address the domestic and behavioural problems. I persistently sought to have my son admitted to the psyche unit at St Vincent's from September 2001 to February2002, and at around October my son had asked for a voluntary respite admission himself but was assessed by the CAT team and refused admission.

Prior to his placement with SFV I had raised concerns about the need to managing my son's psychiatric **and behavioural** problems in a letter dated 19/01/2001 to the Victorian Chief Psychiatrist and these issues were discussed with the Chief Psychiatrist at a meeting on the 9 of February 2001 with my sons treating psychiatrist at Maroondah hospital which was convened by the Director of Clinical Services Mental Health Maroondah Hospital. The issue that was specifically to be discussed was that I alleged that my son was being discriminated against because he was being refused rehabilitative accommodation on the basis of degree of manageability of his psychiatric and behavioural condition. I had made this assertion because most rehabilitative facilities were NGO's and would not accept patients who had a history of violence and substance abuse. The chiefs psychiatrists response to my questions about the adequacy of rehabilitative facilities was that there was additional funding to provide 400 more beds in rehabilitative facilities and when asked if that was enough his reply was how long is a piece of string. There was not agreement with my advocacy that a management plan should include regular testing for substance abuse that if failed might invoke a more restrictive environment and that this should be an element that would be part of the ongoing management strategy of Pavlovian conditioning if cognitive strategies were not effective.

If psychologists were appropriately trained and involved in the clinical treatment of mental illness perhaps their influence would change the prevailing mindset amongst psychiatrists and mental health services that compulsory community treatment regimes do not need to go beyond enforcing medication compliance to a realization that a whole range of behavioural modification and rehabilitative strategies may need to be considered and compulsorily applied. If psychologists were involved and given the legal authority and support necessary to enforce treatment orders there might begin to be a chance families could house someone with a mental illness and build awareness that given the complexity and severity of psychotic illnesses it is often quite beyond the capacity of normal families to be expected to house and preside over the rehabilitation of a family member with such a severe disability. The part time suburban housewife caseworker at the community mental health clinic is simply not equipped to do the job nor are the community drop in centres appropriate for the average young individual in the community exhibiting signs of an underlying psychotic illness which medication might suppress but not completely eliminate.

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The NGO's such as SFV currently providing residential care can only service the easy to manage because they do not have the legal authority to control the behavioural problems of the more difficult categories of psychiatric patients. This is because they do not supervise patients with professional medically qualified staff manning appropriate secure residential facilities. The lack of control options was made obvious when only controlling mechanism available them was eviction of involuntary patients in their care. My son's placement with SFV resulted in his eviction and homelessness within several months of SFV undertaking to care for my son. They wiped their hands of him placing on the footpath outside his flat without an ongoing management strategy.

My son would have had more or less the same level of supervision but much more secure housing tenure in a ministry of housing flat. A ministry flat would have had metal doors and concrete walls and would have been not so easily damaged. He did however appreciate the community atmosphere and lack of isolation in the SFV accommodation and the SFV case managers had established a significant level of trust, but our subsequent experience demonstrated that this trust was misplaced. There was no communication between the SFV case manager and the community mental health clinic case manager there was considerable overlap and duplicity of roles and their combined efforts made little or not difference to the outcome, the registrar at St Vincent's Hospital refused to provide appropriate timely respite in spite of pleas from both parties.

2002 February
After he was evicted from SFV accommodation within 24 hours of his first arrival at my caravan on a vacant block at Loch Sport 300km from Melbourne I was assaulted by my son wielding a stick. The assault was vicious and disturbing, there was no alcohol or marijuana involved at the time and the attack was sudden and unprovoked, I was attempting defer answering his question about whether I though he had a mental illness or not. My son would not stop hitting me until I ran to a neighbour at 2am to request help. The police attended and removed my son from Loch Sport and placed him a Motel in Sale. My son even though receiving biweekly depot medication had been demonstrating high levels of anxiety and violent behaviour since late November 2001 when his sister and her friends came to stay with him and I had been seeking institutional respite for him. After leaving the motel the next day he presented himself to Sale hospital complaining of a sore hand and was admitted as a voluntary patient to Latrobe hospital psych unit and as he was still officially a Clarendon Clinic patient he transferred to St Vincent's unit for a month or so.

2002 August, My son returned to Loch Sport his medication had been adjusted up from 150 mg to 400mg of Zuclopenthixal while in hospital and 300mg following his release. He complained that the high dose produced drowsiness and an inability to control the involuntary shutting of his eyelids and was unable to drive a car as a result.
Loch Sport only has a public bus service twice a week so therapeutic activities such as employment were unavailable to my son. My son seemed generally unhappy and unable to cope with the isolation of living at my beach house even though for a while

he was relatively free of marijuana. My son started to carry out threats to damage my house if family members did not come and attend to his needs and visit him. I attempted to visit on most weekends for several months until other family members and I were reluctant to visit him and be stuck alone with him because of previous repeated assaults damaging my car and other disturbing behaviours.

2003 June
After a year at Loch Sport it was clear my son was not going to be able to work or cope with the isolation of the place. I decided to move to an acreage property I had acquired in QLD and I attempted to move my son who was now 21 as well.

When my son arrived in QLD I delivered a letter to the registrar at Nambour Hospital Mental Health services requesting that my sons' involuntary medication be continued and was told to get Sale Mental Health to refer my son's files to the CAT team in Maroochydore. Besides cancelling the CTO in Victoria nothing much else happened.
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In the mean time my son had 3 visits over 4 weeks or so to a private psychiatrist at Lyrebird Specialist Centre Buderim. On the second visit the psychiatrist without warning me read to my son extracts from the confidential letter I had written him requesting that if possible he treat my son with a combination of base line compulsory depot medication and oral medication to be taken voluntarily as a strategy to help my son's attainment of insight into his illness. The effect of this action occurred immediately after the appointment outside the psychiatrist's office my son grabbed me by the throat and screaming abuse threatened to kill me. No action was taken by the psychiatrist to contact either the Maroochy CAT team or Nambour hospital. **The psychiatrists concluding remarks after reviewing my son's files and the interviews were to the effect that my son suffered from either paranoid schizophrenia or drug induced psychosis but had no insight into his illness and if he did not continue with his medication it was extremely dangerous as there was a strong likelihood he would harm himself or someone else.** Even so it seemed to be beyond the psychiatrist's capacity to make a professional judgment and refer my son to the local CAT team or registrar at Nambour stating it would be necessary to establish my son as an involuntary patient living in the community for the purpose of continuity of antipsychotic medication.

After further prompting by me the medical GP who referred my son to the psychiatrist applied a standard test for involuntary status to my son which was supplied by the Maroochy CAT team. My son was showing few signs of psychosis so this did not precipitate any action from QLD Mental Health Services because at the time my son was complying with his medication. A more appropriate test to apply in this situation would have been an assessment of my son's insight into an already existing diagnosis of paranoid schizophrenia and his likelihood to continue compliance with medication.
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During this period from June to September 2003 my son lived and worked 30hrs per week in a voluntary capacity for his food and keep in the kitchen and on a building site at an Institute for Tibetan Buddhist Studies in QLD. This was the first time he had continuing employment since the onset of his illness and it was the happiest and most normal behaviour I had seen since the onset of his illness he was accepted and successfully working and socializing with competent peers of his own age.

2000 17th September My son moved to my vacant land at the nearby town after a fight with another volunteer when I had gone to Melbourne for a weeks break to see my defacto partner and attend my sisters wedding, my family didn't want my son to attend. After my return at around the 20th of September my son had to cease his voluntary work because he cut his hand severely, severing a tendon when he punched the window of the caravan in which he was living, my son was assessed by the psychiatric register at Nambour Hospital but not admitted as a psychiatric patient and returned into my care after about four days in the general ward, during this time the case worker from Nambour mental health that had been assigned to my son failed to visit him although this was requested.

2000 27th of September my son became angry because I would not drop my planned laundry activities look for a particular hat that he had misplaced and he felt he needed prior to going out. On returning from the laundry I found my living quarters turned upside down and my caravan annex bent and broken by my son. At which time I agreed to my sons request to be put on a flight to Melbourne to visit his mother and return to Loch Sport.

In October 2003 I contacted a worker at Sale Mental Health and informed her that I thought my son needed a psychiatric assessment because he had been unmedicated since the beginning of September and in a phone conversation to me had indicated his dog could understand the difference between 10's 100's and 1000's and requested that a case manager be reassigned to my son and that his CTO be re-established. I was told I would need to request to send the CAT team. I didn't do this because I though it would be futile he had recently been assessed many times in QLD and also since I was living 2,000 kilometres away I was frustrated that the entire responsibility for monitoring and initiating the continuing treatment of my son should be endlessly directed back to me. With some exceptions my son seemed to be generally rational enough in phone conversation and I was unaware of his complete inability to care for himself at the time.

Around the 14th of November My son's 22 birthday there was a fight at a friends place in Sale and a subsequent incident which resulted in my son being charged by Sale Police with breaking and entering or attempted burglary. I'm not sure if a psychiatric assessment was done at the time.

Between November and December 2003 the post Mistress at Loch Sport rang the Sale police because my son had chased her 11 year old daughter more than a kilometre through town but the police declined attending to the complaint. Apparently the local children had been in the habit of throwing stones at my son at the time, presumably because of his obvious and generally inappropriate behaviour.

On Saturday the 20th of December 2003 I was informed by my mother that my son had voluntarily admitted himself to Latrobe Hospital having allegedly slashed a male neighbour multiple times with a knife which nearly caused the mans death and did result in severe lacerations and possible loss of use of the mans eye. A Detective from Sale is the prosecuting officer of my son in regard to the incident.

At Latrobe Hospital on 24th December 2003 My son agreed to voluntarily take Chlopromaline 100mg daily and was given 3 or 4 days supply and he was left to arrange further medication from his GP. I was told that my son was to be released into his mothers care. I was told my son did not have any signs of psychosis that would allow his involuntary sectioning as his problems were mainly behavioural problems but he was given antipsychotic medication that he had agreed to self administer.

I then attended the now pointless management meeting with the new case manager at Sale and again expressed my concerns about the potential for serious violence and harm that may occur due to my son's release.

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Later that day I visited Loch Sport and found that the only door of the converted garage that acted as my son's bedroom had been locked and barricaded from the inside and my son had been entering through a hole at about chest hight in a side wall to an adjoining double garage. In his living quarters there was a 20 gallon rubbish bin full of urine and about 2 months worth of domestic rubbish infested with maggots strewn about the room, there was also blood and evidence of the assault and scuffle. There was a hole in the earth floor of the garage next door where my son had started to excavate for the aquarium in which he intended to and keep sharks. In the main house nearly every window was smashed and there were numerous holes in the exterior and interior cement sheeting of the house.

I was extremely worried for the safety of my son and those that came into contact with him; experience has demonstrated it takes at least 2 months for my son's general mood and manageableness to return to a level which may allow him to function without incident in the community for a few months. If he is not isolated medicated and cared for his mood is persistently angry and his stress levels, irrational beliefs and manic behaviour also increase. He then benefits from appropriate medication in an isolated environment, free of excessive stimulation and stress and intoxicants.

My son raised his voice at his mother and his mother's boyfriend fought with my son bruising his own nose when my son head butted him and my son was again evicted from his mothers on the evening of the 24th of December. Having flown down from QLD I collected my son from Maroondah hospital emergency ward at 5am on the morning of the 25th of December where my son had presented for admission and placed him in Badger Creek Caravan Park Healesville paying for a week. After he stayed one night the manager rang me requesting his eviction due to the behaviour of urinating in inappropriate locations and commenting his conversation seemed abnormal. The police removed my son and he resided temporarily with his mother or in a caravan at a nearby friends.

My son had in my opinion fulfilled grounds for an involuntary psychiatric admission yet during this period my son was refused admission to the two main hospitals that had been treating him since he was 17, Maroondah Hospital and Latrobe Regional Hospital.

It is my opinion that Mental Health Services Victoria has been negligent in discharging is obligation provided for in the Victorian Mental Health act 1986 No.59/1986 section 5
(a) iii "minimise the adverse effects of mental illness on family life".

And
It is stated in Section 4 Objects of the Act 2 (a) "Persons who are mentally ill receive the best possible care and treatment in the least restrictive environment **enabling care and treatment to be effectively given"**

When that patient has committed a murderous act and is released from hospital and is not placed on a community treatment order and no strategy is in place control substance abuse which counteracts the anti-psychotic medication and they are not placed in a secure residential rehabilitative facility but are homeless or their families are forced to care for them it is a clear breach of both of the Mental Health act sections above. As a carer I am not in a position to prosecute these claims as I am not seen to be the injured party.

It is my strong view that on 23rd December 2003 when he was released from the Latrobe Hospital my son was a danger to himself and a danger to others but no realistic and effective management plan was established.
His history over the last few years demonstrated that in his disturbed mood he was likely to harm others or himself. I warned the hospital and Mental Health Services in the clearest terms of the above and I was ignored.

2004
In January my son was eventually picked up by police in Wangaratta jumping out in front of traffic on the Hume Highway and was made an involuntary patient. He was heading back up to Queensland.
My son was returned to Latrobe Hospital and from there he was transferred to the Melbourne Assessment Prison in February there he remained unmedicated a month or so in the remand centre until he was showing clear signs of acute psychosis that facilitated as transfer to the Thomas Embling Forensic Psychiatric Hospital.

2004 March
On arriving in Thomas Embling my son broke another patients jaw and in this environment he has taken a long time to respond to various medications, and spent the first 2 or 3 months in and out of solitary isolation.

2004 September
It took nearly eight months for my son to stabilize his mood on the various antipsychotic medications tried. By September he attained a mental state where I felt relatively safe having visits not attended by a staff member I was a little wary because in December 2003 during a visit my son assaulted me at Latrobe Hospital and I received an injury that required four stiches to my scalp. The medication being used is one of the strongest available a large dose can be given with few side effects such as drowsiness, it cannot be given in the form of a biweekly injection and due to its toxicity it requires periodic monitoring of white and red blood cells.

2005 March 29
My son will face charges for assault causing serious injury and at this time the treating psychiatrist in consultation with my son has agreed that he will not prevent my son from serving a custodial sentence in the general prison system due to the demand for forensic psychiatric facilities, and in preparing a report for the trial his assessment is that my son was not mentally impaired at the time of the offence. My

son has a choice to plead guilty acknowledging he was aware his actions were wrong at the time of his assault of his neighbour and receive a finite sentence,(his barrister has suggested may be likely to be eight years) or plead mental impairment which his treating psychiatrist has indicated is more onerous as the time of physical restraint is indefinite and at the discretion of the chief psychiatrist.

If my son re-enters the prison system it will mean his medication cannot be compulsorily administered if my son refuses his medication and becomes unwell he may be returned to Forensic Care or if his sentence has expired he may be released in an unwell state back into the community. .

2005 April
My son was transferred to remand centre in Melbourne to see if he will cope in the general prison population, the psychiatrist in charge of the psych ward at the remand centre will observe if medication offered is taken on a voluntary basis.

2005 21 April
My son was transferred back to Thomas Embling. The MAP psychiatrist considers it will be un likely he will comply with his medication and non-compliance with his medication for a period of four days will necessitate a whole series of tests monitoring his white and red blood cells when medication is reintroduced. There are signs of increased psychosis as a result of abstaining from medication for a number of days in MAP.

What is needed from a carers point of view
There is a lack of meaningful measurement of the effects of government policies.
Mortality rate trends amongst the mentally ill need to be measured in an ongoing way. A particular emphasis is needed in tracking the overall mortality rate and causes of death in the first 10 year period from the time of first admission because this is the approximate adjustment period to living with mental illness . Quality of life also needs to be measured.
In spite of advances in the effectiveness of medication for psychotic and depressive illness inadequate management practices tolerate increasing mortality rates in the mentally ill particularly for those in the first 10 years of their illness. Some estimates are as high as a mortality rate of %50 for males in the first 10 years of their illness; the National Health Survey suggests schizophrenics are approximately 3 times more likely to die of natural causes than the general population

The biggest barrier to community based care being workable has been the wording of involuntary treatment legislation.
Currently demonstrating need for intervention and access to residential psychiatric facilities or CTO falls on the carer or the patient fulfilling an indeterminate criterion. This situation seems to absolve psychiatric facilities of due responsibility and accountability for the ensuing lack of appropriate medical and psychosocial intervention.

The burden of proof needs to be shifted back to health care professionals representing Mental Health Services to demonstrate that there are strategies in place that replicate the beneficial aspects of support for treatment provided by residential psychiatric

facilities and that the patient will not be socially isolated and will be able to function normally and without serious incident when released into the community.

The multitude of separate organizations involved community based care and regionalized services are what provide the cracks that the difficult to manage fall through. In many ways compared to many countries the system is generous in providing disability pensions and free antipsychotic medication. However lacking support and supervision and the absence of water tight management strategies for those with mental illness this well intended generosity does not translate in to lower mortality rates and better quality of life for the mentally ill, their families and a general feeling of security and wellbeing in the community.

A comprehensive strategy to improve the performance and public confidence in community based care.
This requires a vast increase in secure supervised accommodation with secure restriction of freedom available to the supervisor on demand and an instantaneous response when behavioural problems occur. Therapy and monitoring of a patients ability to maintain a safe standard of domestic hygiene needs to be a part of this program. The companionship and ability to co-habit with others with similar problems would help with the need to develop an ability to respect the rights of others who share his living space. Public hospital psych ward facilities only have very limited secure facilities. The bulk of psychiatric patients in public psychiatric wards have access to illicit drugs and alcohol as they are in general free to wander the surrounding suburbs.

There needs to be opportunity and requirement to work and acquire life skills.
My son has demonstrated recently in a commercial kitchen and prior to the onset of his illness when he worked at Peninsular Prefabs that he benefits from the more structured lifestyle employment requires. My son can be motivated by a desire for money and the self esteem of being a competent member of a team. He can obtain good references from both his employers. He has a work ethic that may be his strongest rehabilitative asset and would provide an opportunity to socialize with others unaffected by mental illness. But he has also demonstrated he is easily distracted and needs strict and close supervision and prompting and strong incentives to establish him and for him to continue in employment.

A national strategy is necessary for unflawed community treatment orders for the continuance of supervised medication and the opportunity of continuing psychiatric care in an unaltered way if a patient choses to move across State Boundaries as there is no policing or restriction of those wishing to cross state boundaries.
In Queensland introduction of the Mental Health Act 2000 provides the legislative capacity to transfer involuntary treatment orders interstate. This is a significant step in the right direction. It still does not address the problems of lack of treatment that my son encountered after his first hospital admission prior to gaining involuntary community treatment status. The remaining major problems areas that still need to be addressed involve extending involuntary care procedures to include a wider range of treatment options than just the compulsory administration of medication.

The prescribed appropriate medication should be of the type and amount and delivery mechanism to be negotiated in an ongoing way with the patient. If a medication regime is changed it should have no side effects, or effects that are a compromise between the patients demonstrated ability to take care of his own mental health the professional judgement of a treating psychiatrist. Even if compliance monitoring requires daily or weekly urine samples or continuing residence within a mental health service community care unit it should be continued until professionals are confident some other compliance strategy will be adequate.

Continuing Psychotherapy: individual and group sessions: my son has expressed an inconsistent willingness to engage in psychotherapy to deal with his anger, substance abuse, behavioural and socialisation problems these services to not seem to be apparent in the community even if he were willing to participate. The Eltham private community mental health clinic has closed down due to the founding psychiatrist retirement, it consisted of a psychiatrist who bulk billed, supported by a number of clinical psychologists and included elements such as psychodrama, music therapy, filmed group therapy much of which was not supported by medical insurance schemes. I am not aware of another similar private facility anywhere in Australia. Some sort of carrot and stick approach to participation needs to be applied to get patients into continuing psychotherapy but the facilities have to exist and be affordable for this to be possible. Because developing insight into their illness is so difficult for some patients with a mental illness and yet is so essential to a good prognosis, it is imperative that patients are filmed and their conversation recorded on admission to hospital and patients need to be confronted with these records of their behaviour at therapy sessions so they are able to have a professional review and discussion about their progress prior to release and at other times when it is appropriate to reinforce their developing insight.

There is an urgent need for Long Term Residential Community Care Units.
There is no point employing case managers to refer patients to Salvation Army hostels for the homeless. This type of discussion frequently occurs when devising management strategies with case managers who act as referral agents to non-existent mental health facilities. The money funding case managers in existing non residential community health clinics would be better spent on bricks and mortar for residential facilities.

Involuntary Status legislation needs to be reviewed in all states.
The fear of an Orwellian world where patients are unnecessarily medicated for political ends is probably unrealistic but the overmedicating of the difficult to manage in a form of chemical straight jacket is definitely occurring and needs to be guarded against.
When considering involuntary status there needs to be a differentiation between completely autonomous and independently living adults with serious mental illness who are not violent and those who depend on carers for accommodation and support who are violent. The human rights of these autonomous consumers of mental health services of course needs to be given greater due weight.

The human rights of patients who are violent needs to be weighed up against other risks to the patient and the community**.**

Only the consumers of mental health services know the real extent of their suffering when subjected to involuntary treatments, and they should be given a much higher degree of support if subjected to these involuntary treatments.
My son has said he does intend to end his life if he is forced to continue with the sort of medication regimes he has in the past been subjected to. I take this threat very seriously and will continue to advocate for an appropriate balance my son's personal freedom and enforced compliance. This is why one of the primary goals of cognitive treatment must be the development of insight and periodic variation or ceasing of medication in a safe environment. It was obvious when my son worked in Queensland in 2003 that he was able to function much better on biweekly 150milligrams of Zuclopenthixol than the 300mg he was being given in Victoria I am pretty sure he would have had difficulty working on the higher dose because of the ensuing drowsiness and lack of motivation. Real consideration needs to be given to how a person is coping with being involuntarily subjected to medication regimes for years on end. There is a review process but it is at this point that the almost complete absence of the cognitive therapist involvement in the clinical treatment and psycho social rehabilitation of the mentally ill is most obvious.

Many of the problems my son experienced were due to the absence of appropriate psycho social rehabilitative environments and variations of intervention have tended towards higher levels of medication rather than higher level of psycho social support and isolation from stress and intoxicants. The higher levels of medication may have further hampered the problems of rehabilitation and finding a niche in society by preventing things as simple as my son from driving which may have enabled him to find work.

My son has demonstrated while working at the Buddhist Institute in QLD an environment that might approximate an ideal highly supportive, culturally appropriate environment for my son where there is a level of physical isolation from mainstream society, values and rules limiting intoxicant use, motivators such as the wish to be accepted by working peers and socializing with opposite gender peers who are fully functional adults and are the sort of environments where antipsychotic medication can be reduced to the lowest possible levels. This might be attributable to the normalising effect on my son' behaviour of association with competent peers as apposed to the radicalising effect of association with less competent peers in psych wards and the like. Also in highly supported environments more modern and specific medications that are produced only in forms to be taken in daily oral doses can be utilized. These have less undesirable side effects than current biweekly depot medications.

I wish to stress that it has been my experience to observe that the single most effective intervention strategy that has assisted with my son's ability to function more or less as a normal person is antipsychotic medication. The regular compulsory application of antipsychotic medication for those who have little or no insight into their own illness is necessary. Those who assert that this compulsory application of antipsychotic medication is a violation of human rights cannot have had much exposure to those suffering acute mental illness nor much appreciation of the physiological basis for illnesses such as schizophrenia and many other mental health problems. I do not mean to imply that cognitive therapies, appropriate diet and exercise cannot also be critical to addressing what physiological imbalance exists in a patient.

Even though meeting the psychosocial needs of patients is desirable it is in reality beyond the capacity of current mental health strategies which cannot even manage the physiological treatments adequately. When examining the reasons why this is true it is apparent that one of the main reasons cited for denial of respite and involuntary admission and medication has been the interpretation of Mental Health Acts. These Acts are designed to provide a legal framework as a basis from which treatment of a patient can commence but are interpreted in an absurdly distorted way that emphasises protection of a mentally ill patient's "human rights" to refuse treatment over the professional judgment of a treating psychiatrist that treatment is necessary.

All practicing clinical psychologists should be trained in the clinical treatment of mental illness by psychiatrists and they should have hands on experience in psych wards in the same way doctors are trained in public hospitals.
Although it is acknowledged it is difficult to engage in cognitive therapy with unwilling patients who have involuntary status, if avoiding this involuntary status is the area psychologists consider to be critical to delivering adequate mental health services in Australia it is further evidence of psychologists lack of training and exposure to the realities of managing serious mental illness, and one might argue they need to get out more.

The absence of psychologists' involvement in the clinical treatment of mental illness is a major waste of valuable human and educational resources. The intellectual rigor of psychologists training makes them powerful researchers and analysts, it's a pity the academic endeavours of psychologists have not focused of doing meaningful and relevant statistical research into the major problems in serious mental illness, that would enable unequivocal sheeting home of responsibility for outcomes like increased mortality rates from mental illness to the relevant Health Ministers.

Psychologists' papers and thesis which reflect the idealization of Mental Health Management strategies and community based treatments may be influencing public policy and opinion possibly because public administration is one of the few vocational options available to them. Advocates of community based care have contributed to the destruction of all of the previously existing mental health facilities in Australia, it will now be required that there is an admission of the failure of these policies by governments to enable significant additional expenditure to recreate and reinvent those previously existent long term residential facilities.

Whatever the source of their ideas advocates and implementers of community based care have not acknowledged and emphasised the continuing need for long term residential care facilities for involuntary patients nor attempted to measure the effects of these changes from residential institutional care of those with mental illness. Even though due to actually treating a patient there probably has never been a successfully contested case of human rights abuse or medical malpractice in the Mental Health System in Australia (with the exception of deep sleep experiments in Queensland). This ethereal body of human rights activists (possibly the subliminal influence of the idealizing psychologists and cost cutting politicians) that Mental Health professional seem live in fear of tends to make them very reluctant proponents of involuntary treatment regimes.

This cogitation in regard to making professional judgments in regard to involuntary treatments has been implemented with almost complete indifference to wellbeing of consumers of Mental Health Services. This cultural and legal framework for treating the mentally ill probably deters the establishment of private clinical psychiatric facilities for medium to long term care and rehabilitation. Psychiatrists and those involved in clinical treatment regimes seem to be unable to freely exercise their professional judgements because they are without the appropriate secure long term residential facilities which are an essential part of the exercise of their profession and they are overworked and measured by meaningless performance indicators like throughput of patients and reduced times of stay. They don't seem to have the additional time and recourses to explore new and creative uses of their legal authority in combating mental illness. They are under resourced and at the coalface of an unworkable system.

The main thrust of my discussions with trained psychologists and the quasi professional social worker case managers after my son's first acute admission in reference to treatment resistant and often threatening behaviour, was behavioural modification strategies which, if not complied with would ultimately lead to eviction, (a dangerous strategy for a young mentally ill person when there are no receiving residential rehabilitative facilities). This type of counselling, mislabelling psychosis associated with problems such as violence and substance abuse as "behavioural problems" and wishing to apply behavioural modification techniques to someone who has an untreated physiological disorder of the mind is common, dangerous and in my opinion quite irresponsible. The psychologists I consulted did not know the steps which one might carry out and the requirements that might need to be fulfilled to gain re-admission of my son to a psychiatric facility. Practical experience has since taught me that there are no concrete requirements and gaining access to psychiatric facilities is governed by arbitrary criteria.

The lack of accountability of Mental Health Service providers needs to be addressed.

As a carer I am naturally partially focused on the unfair treatment carers are subjected to by Mental Health Services and at the hands of those who are mentally ill because carers charges are dependent and not autonomous they rely on family for accommodation and support and also often have substance abuse and violence problems as well as varying levels of psychosis. The existing legislation governing the rights and responsibilities and relationship between the patients, carers, the community and Mental Health Services are severely flawed open to varied and bizarre interpretation and are in need of redress.

The rights of the carers need to have a recognised legal status that gives them access to the medical records of their charge and they need to have legal the right to demand that the mentally ill person they are caring for, be removed from their residence and housed indefinitely in a secure and appropriate residential psychiatric rehabilitative facility when appropriate. In addition a carer's legal status should permit them to seek legal redress for damages if Mental Health Services fall short of what can be reasonably expected.

The inability of Health Care Professionals to make accurate judgments in regard to the need for care in a residential facility is facilitated by lack of accountability.

Any inquiry into the quality of decision making is easily deflected. For example my complaints to the Victorian ombudsman in an email dated 5/1/04 in regard to the Sale police forces failure to remand my son in custody after the stabbing incident in December 2003 and Latrobe Regional Hospital's failure to section my son after the same incident have not elicited an adequate explanation of events.

A reply to my email from a senior investigator of the Ombudsmans office suggested that I take these issues up with the Chief Psychiatrist. I wrote to the Minister for Health and received a reply from Acting Minister for Health dated 11/2/04 stating she requested an update from Chief Psychiatrist Victoria and I was informed my son was at that time being treated as an inpatient at Latrobe Hospital and that he was to be assessed by forensic services.

The fact that my son had been unsupervised and unmedicated and at large in the community for a number of weeks since the assault in late December 2003 early January 2004 which nearly killed someone does not seem to be an issue worthy of investigation in the minds of these departmental heads. I received a letter from the chief psychiatrist to the same effect, sidestepping the possible breaches of the Mental Health Act that Latrobe and Maroondah Hospitals had engaged in. The Chief Psychiatrist suggested that I refer ongoing management issues to Director of Psychiatry at Latrobe Regional Hospital.

I have not sought an explanation in regard to my son's repeated failed attempts at admission to Maroondah Hospital in late December 2003 and early January 2004. At the time accessing inpatient treatment was the most important issue and since he was eventually admitted to a long term psychiatric facility with only one further incidence of serious injury to someone after an unmedicated period in Melbourne Assessment Prison(MAP) I have not pursued these issues further but I believe it should be a matter of ongoing investigation.

I believe the assessment of my sons condition at the time was gross medical negligence because even though he may have appeared rational for a limited period of time extended observation and appropriate probing would certainly have revealed he was at least was experiencing high levels of anxiety which was for my son a persistent indicator of an approaching period of acute psychosis and in addition no corroborating evidence such as investigating my sons living conditions and interviewing neighbours was sought to determine my sons mental state at the time of the stabbing.

My son already had a pre existing diagnosis of Paranoid Schizophrenia that had been determined by a number of competent psychiatrists over the previous four years he had for the previous two years been assessed as needing a CTO to administer antipsychotic medication, there was evidence of unreasonable beliefs and serious violence had occurred, and this was happening at a time when my son had ceased taking his medication for a period of at least five months. If medical intervention is not forthcoming and predictable in these circumstances what possible set of conditions might require access to residential psychiatric facilities.

In addition this clinical assessment of "Not being mentally impaired at the time of the assault" is an incomprehensible distinction when applied to someone who has chronic schizophrenia yet it may have a bearing on later criminal proceedings and is

demonstrably invalid as it took my son a further 12 months of residential forensic psychiatric care and antipsychotic medication to be assessed as well enough to stand trial.

Conclusion

I hope this account will be of use, most people I have encountered in the course of my son's treatment including the police have been sympathetic compassionate people often going beyond the call of duty doing a difficult job to the best of their ability and I have a genuine sense of gratitude for their work while my son has been in or accessing psychiatric facilities in spite of their repeated failures to deliver appropriate services in a timely way.

I believe the problems that we have encountered are systemic and what is needed is a shift in culture particularly from our policy makers and legislators and a vast increase availability of recourses for involuntary intervention and residential psycho social rehabilitation. This would ideally be driven from the top down but as it is a matter of urgency I implore health care professionals to devise water tight psycho-social rehabilitative strategies to be involuntary applied if necessary and treat the confounding behaviours such substance abuse and violence as part of your duty of care. Take appropriate steps to monitor and prosecute these behaviours assist and encourage families to have magistrate's orders in place to control these negative behaviours by providing secure respite for those who have breached magistrates orders before mental illness and negative behaviours become a reason for the complete social disruption of the patients and families lives.

Today there are many shortcomings in social policy which amongst other things is a failure to treat the mentally ill, absence of effective early intervention programs that have the teeth to ensure compliance with behavioural modification approaches, absence of effective parenting educational centres in crèches and schools and on the internet that monitor and build competent parenting skills.

Failure to take adequate steps to limit illicite drug use by vigorously identifying confronting, prosecuting and treating illicit drug users in suitable programs as well as sufficiently severe penalties that would deter and remove career traffickers from the community.
For example while wandering in Sale in 2003 my son was fined $100 dollars for drinking beer in a public place but had the marijuana he was carrying confiscated without a charge.

There is a failure to implement the generalised use of sniffer dogs and testing of members of community for illicit substances when entering hospitals, prisons, schools, at work and on the road. There are unresponsive policies that for example for the last thirty years have stringently policed alcohol consumption in motor vehicles while ignoring drug use in vehicles which are in effect policies that encourage drug use and consequently the incidence of psychosis and are evidence of lack of clear focus of our policy makers and the general community of the real issues affecting our society.

The unresponsiveness of policy makers is a problem greatly exacerbated by the political manipulation and dumbing down of the media by the influence of conglomerated news outlets, media monopolies and politicians wishing to maintain office. In a period of great social change, decay and decline of the family, the cultural religious and employment structures that facilitated the social cohesion of the last centauries it is easy to loose sight of what the necessary ingredients for a happy and prosperous society are.

For example in a recent national press club address a bio ethicist professor put forward the proposition that medicine in addition to treating illness should also enhance human life by cosmetic surgery etc, and research should not be unduly restricted by conservative and religious thinking, a proposition that would be acceptable to most people, but he crossed the line of plausibility suggesting a legal future for designer drugs. A more solid grounding in the thinking of humanities great religious leaders in regard to the development of a healthy human psyche would prevent one from undervaluing the teaching to humans the capacity for restraint and would provide one with many reasons why we should not allow any expansion of available intoxicants in our society. To impose restraint on those who have little capacity for it is indeed an onerous task however. Perhaps this is why those with purely scientific or legal backgrounds have so much trepidation and moral dilemma about the development and imposition of enforceable restraints which are a necessary part of clinical treatments for the mentally ill. Politicians, medical scientists and lawyers alone don't have the depth of understanding of the human psyche to draft the appropriate legislation to provide a less ambiguous legal framework in which to treat the mentally ill we should therefore definitely include scholars trained in religious thinking and ethics to synthesis an appropriate set of criteria to determine mental illness and the need for intervention. This would ensure that the mentally ill receive the same level of medical expertise and care that is expected in regard to other illnesses such as heart disease and cancer.

For the above reasons it is virtually impossible to stabilise acute phases of mental illness in a community based setting, without recourse to lengthy stays in facilities that insulate patients from mainstream society. Today in an urban environment these would have to be secure facilities like current forensic psychiatric care facilities as a behavioural modification technique and as an environment from which long term rehabilitation might commence.

When Australian citizens with mental illness end up in refugee detention centres or get deported it is not just a failure of immigration authorities and it is a pity the focus of the media has been shifted to this sector of governance and very convienient for some politicians. The real failure in both these cases is primarily a failure of mental health services in Australia and many thousands more people are adversely affected and die as a result of these failures than the handful of refuges affected by immigration policies however harsh they may be. The real mortality rate from these failures in Mental Health services is about 3 times the road toll if one considers 1.5% of the total population have a long term mental illness and only 50% survive the first 10 years due to accident, illness, substance abuse and suicide, this amounts to about 150,000 to 300,000 unnecessary deaths over a 10 year period.

It is a sad indictment of our societies indifference in regard to the proper treatment of mental illness that the only effective strategy my son had at his disposal to change his situation and access the only available form of residential care (prison), was to display his complete inability to cope unassisted with his illness by assaulting someone with a knife. It is an all too regular and often tragic news worthy event when others with similar problems are driven to violent acts by their mental illness and the neglect shown to them by our society.

Supporting Statistics

National Health Survey

Trends and differentials

Limited information is available to establish trends and differentials for mental health in Australia. Bennett et al. (1994) have recently reported on trends in mortality from 1980 to 1992 which reveals that mortality from all mental disorders is increasing annually at 4.0% in men and 4.6% in women. The highest rates of change in death rate are noticed for drug dependence in men (7.4%) and senile and presenile organic psychotic conditions in women (5.8%).

The male suicide rate gradually increased from 17.9 deaths per 100,000 in 1981 to 20.9 deaths per 100,000 in 1992 (with an annual rate of change of 1.9%).

The 1989–90

National Health Survey estimated that some 3.5% of the population, or 599,000 people, suffer from one or more mental disorders (Australian Bureau of Statistics 1991). Almost one-half of these had the problem (excluding retardation and specific delays in development) as a long-term condition.