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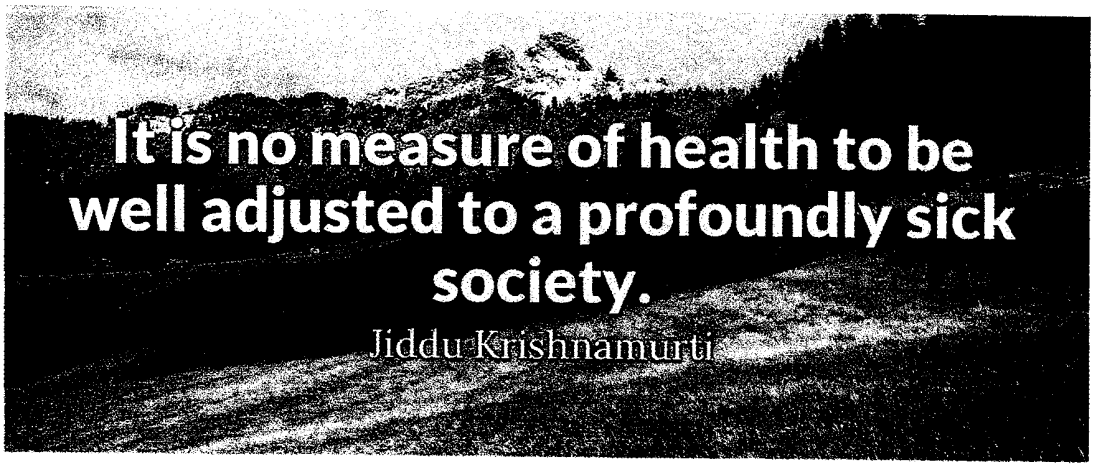


As psychiatrists we need to be active in the event of a Royal Commission. The perspective must be broader than what we as mental health professionals generally acknowledge. It is not purely access to psychiatric care and a reliance on psycho-pharmaceuticals. Our prisons abound with people with a psychiatric illness, indigenous people, substance abusers and women many of whom have histories of abuse. Homeless numbers swell with all of the above; suicides increase.

Fifty years ago alcohol and drug services were separate from psychiatric hospitals with patients transferred between systems as required. As institutions presented their own problems deinstitutionalisation became the obvious solution. Poorly implemented and under-resourced there were significant problems in the implementation of community care from the 1970's onward.

There were centres of excellence but many mental health consumers fell between the cracks; they vegetated, suicided and avoided care.

Case management community services improved. Some received the benefits others did not. Gradually these services became attenuated and time limited. Serious psychiatric illness cannot be time limited. Continuity of care is paramount. Carer involvement and psych advocates are often token.

The revolving door continued to revolve. Several factors fuelled recidivism. It is an oversimplification to level the blame on illicit drug use and inadequate funding for psychiatric services.

The real needs to be addressed are basic human rights; the right to shelter, food, work, financial support, dignity and hope. Sociological changes have driven the increasing numbers of children, adolescents, adult and aged mental health problems.

Executives, developers and otherwise reasonable people step over the homeless in the street. The blame the victim message is clear.

Employment opportunities are few. Not only those with psychiatric illness but the young, the disabled, the aged population and women are disadvantaged creating despondency and all the sequel of poverty.

Unemployment, homelessness, poverty and disconnection result in loss of hope, the very genesis of mental instability.

There is no living wage. Disability Support Pensions barely sustain housing, food and bills. Youth allowances do not enable independent living nor do unemployment benefits. With NDIS and current stringent DSP rulings fewer have the benefit of a DSP. Job search allowance and the statutory requirements for people to work with private, often corrupt, job agencies is overwhelming for people with and without mental illness.

Fears realistically exist in the psychiatric community that NDIS will assist a minority of people with psychiatric illness. Those with existing or potential DSPs will miss out because they are not disabled enough. A potential giant crack develops again for people with mental health issues. Most people with or without mental illness want to work. Work is not readily available and exploitation is rife in franchises and, anecdotally, job agencies.

People suicide for many reasons. Life has no meaning or the meaning itself is unbearable. Poverty, beyond the obvious need for housing, prevents access to GPs who do not bulk bill. Those who do bulk bill often refuse to fill in forms and do not allow time to discuss complex mental health issues. Access in crisis is unusual. We are now experiencing 6 minute medicine which cannot be satisfying for doctors or for mental health consumers.

Few GPs bulk-bill. GPs who actually spend time with mental health patients are often targeted for using appropriate item numbers. Fewer private psychiatrists bulk-bill. As a result the sickest receive the least care. The lifespan of persons with a severe psychiatric illness are similar to that of indigenous people – a good 20 years less than the rest of the population. Disenfranchised numbers in our population increase.

Organisations such as Beyond Blue and Lifeline, whilst they do limited worthwhile work, ultimately refer people to non-existent services.

Dental care is largely non-existent except in acute situations. Mental health patients are usually offered the opportunity of tooth extractions rather than unaffordable remedial work.

Poverty restricts access to transport, legal representation, education, housing, health services and access to technology.

The impact of environmental toxins is overlooked. Mental health and disenfranchised populations live in unsanitary mould infected buildings. Often they are victims of unscrupulous landlords

Food is an issue. Mental health patients and the poor eat badly. Dr Felice Jacka has highlighted the importance of diet. Hospital food remains appalling – nothing Mediterranean or vegetable based in inpatient units. Patient education is negligible regarding diet and many aspects of care.

We could learn from organisations like ACNEM how to broaden our approach to environmental and nutritional approaches to mental illness.

The importance of the therapeutic relationship has been reduced to pharmaceutical solutions and continuity of care has again been eroded as a concept; an anachronism. All therapies should be trauma informed.

Differences exist between rural and urban communities which have not been adequately addressed. With high city rentals more will move to acquire more affordable housing in areas of poor infrastructure and, in particular, a paucity of mental health services. In rural communities there are few private facilities. Public and private relationships are not always healthy.

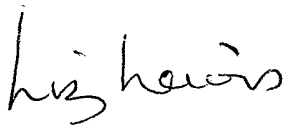
TAFEs have been dismantled, non-government funded drop in centres have gone in order that integration occurred. Stigma continues to prevent integration in a large percentage of our mental health population. Disconnection from others increases. The demise of groups, art, music and dance opportunities thwarts creativity. Inequity and poverty lead to despair. Despair fuels impulsive behaviour, addictions to substances and screens, anxiety and depression and suicide.

It is all stacking up for those with mental illness and the disadvantaged, disenfranchised, disillusioned youth who live in a world without hope which in turn generates mental illness.

Solutions.

1. A living wage
2. Major increases in public housing
3. Reconnection via increased TAFE funding with permanent positions for staff, local clubs for mental health consumers
4. Improved service in Primary Care and mental health services accessible to all community members regardless of financial means
5. Increased detoxification and rehabilitation opportunities for those with addictions and decriminalisation of drug use.
6. Improved dental and physical health of mental health consumers by abolishing gap payments and reimbursements for GPs to enable optimal care.
7. Strengthen carer involvement. Increase numbers of consumer consultancy and peer support workers
8. Trial innovative projects; travel vouchers for those that do not have the money to get to appointments. Introduce PBS nicotine patches for a 12 month period for the severely mentally ill who might eat if they did not smoke.
9. Address the inequality after first acknowledging it. Compare NDIS allocations of urban suburbs like Kew with an economically depressed township like Maryborough.
10. Restrain and monitor rampant use of "pop-up" private facilities run for profit within NDIS, employment agencies and aged care facilities.

Yours sincerely



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