
STORIES OF INJUSTICE AND DESPAIR

The following are just a small sample of the stories and themes of injustice and despair that were revealed during the community consultations and in written submissions. Further stories can be found throughout this report.

Preventable deaths?

[O]ne night [my son] started hallucinating. He was on a trip with a friend in NSW...The hospital called me to let me know what had happened and I was assured he would be OK...The hospital needed to get his patient history from our normal hospital in Echuca [Victoria] but there was a delay in getting this information...The Psychiatric Consultant who examined [my son] phoned me and told me he was going to be discharged as he was only homesick. I pleaded with him not to discharge him as he was really sick and needed help...[My son] was discharged the next morning and on the drive on the way home with his friend he killed his friend because he was still sick and hallucinating. He was sent to jail and had his glasses and hearing aid removed and not returned. He was supposed to be sent to a hospital with a psychiatric ward but instead he was sent to Silver Water jail...That is where he stayed for 2 months...[He was then] moved to Long Bay Jail where he was supposed to undergo a psychiatric assessment prior to his court hearing. On the day of the assessment the doctor never turned up ...and neither did the solicitor who was acting on his behalf. As such the hearing never took place and as a result he became very suicidal...I informed and pleaded with the authorities to make them aware he was sick and suicidal. They informed me he would be put in a cell with another inmate who could watch him but in fact he was placed in a single cell on Friday...and hung himself on the Friday night. I would like to know why he was failed by three government departments? How did this happen? [October 2004]

(Carer, Mother, Victoria, Footscray Forum #8)

His suicide was tragic, made all the more so because it was preventable, we believe, but for the inadequacy of the public mental health system. [X] died just two weeks after his first suicide attempt, eight days after his discharge from the Canberra Hospital psychiatric unit, two days after being refused admission to the psychiatric [unit] following a second suicide attempt, and within hours of contact with the mental health crisis team. On the day of his death, [X] had contact with the mental health system no less than three times. [Suicide occurred early in 2004]

(Anonymous, Australian Capital Territory, Submission #288)

I was amazed on one of my visits to see my mother so distressed that after two days they were sending her home to us the family to give the care she had not received in the Hospital. May I add also that this particular incident occurred after her third attempt on life. She was so frightened because she knew she was not any better...it was having a huge affect on the whole family. The answer to my question to the doctor about how many attempts would be enough. Apparently the answer to that question as found out was five. Because on the fifth occasion, at approximately 1:30pm on the 15th October 2003, my mum decided to douse herself in petrol and set herself alight.

(Carer, Son, Queensland, Submission #184)

When is a crisis a crisis?

In the past I have been told by CAT [Crisis Assessment and Treatment] team members whilst in crisis "You know more about your diagnosis than we do, Call us back if you can't get it under control". In those days control usually meant I would SM [self mutilate] so badly I would have to sew or patch myself up. How far does a person have to go to say I need help and I need it now?

(Consumer, Victoria, Submission #112)

My sister had suffered with bi polar disorder for 30 years...Sadly she took her life on 18th June 2004. On that day I was going to take her shopping but she didn't feel well. She said to me what about Psychiatric Services. But she always presented so well when they interviewed her that I knew they wouldn't take her in, so I took her home. She said she felt better just talking to me on the way over to our place. And many times over the years I would bring her home for a few days or a week to help her get over her depression. The next day I was going to be home at 2:00pm from work. That morning she took her life. What a waste of life. If only the system had a more open door policy. I wouldn't feel so guilty for leaving her that day.

(Carer, Sister, Victoria, Submission #286)

A failing community care system?

The dream of closing psychiatric institutions and moving towards community based care has turned into a nightmare. Community care is under resourced and integrated services are lacking. Too many people are denied treatment and slip through the gaps.

(ARAFMI Tasmania, Tasmania, Submission #245)

The system is chronically under-funded and under-resourced. There is a chronic shortage of psychiatric beds. Community Clinics are overworked and under-resourced. Supported accommodation options for mental health clients are severely lacking. The Psychiatric Emergency Service is viewed as a joke by clinicians and clients alike and functions as little more than a telephone advisory service.

(Clinician, Western Australia, Submission #4)

Early intervention – reality versus rhetoric?

Regarding 'involuntary intervention'; although the Mental Health System espouses 'early intervention' and carers are encouraged to practice this, the constraints surrounding 'involuntary intervention' can make 'early intervention' impossible. From personal experience, it means that intervention will not be carried out without the consumer's consent until that person is acutely unwell and a 'crisis situation' arises. Although it will then, still be without the consumer's consent, probably even more so, and will probably mean a more forceful intervention, somehow this policy is considered more humane...As ridiculous as it sounds, it means that the behaviour of the unwell person has to disturb, alarm or frighten a member of the public enough to bring it to the attention of the police or the Mental Health Service - a carer's word that the person is at risk is not enough...and we talk about reducing the stigma of mental illness.

(Carer, Mother, Victoria, Submission #178)

Where is the follow-up care?

After exhibiting psychotic behaviour my son spent 21 days (detained) in Glenside Hospital in March 2002. He was counselled and medicated then turned out into the community with some medication but no follow up care. Shortly afterwards he stopped his medication, reverted to his anti-social, aggressive and irrational behaviour, a state he has been in unchecked for two years.

(Carer, Mother, South Australia, Submission #11)

Families and carers taking the brunt?

Major service gaps are on the rise, with plans, strategies, and government promises failing to meet the needs of this vulnerable community group. This results in carers, families and the community sector, being forced to take the brunt. As a result, the community sector feels under constant pressure to respond to hopelessness, helplessness, and the despair felt among consumers / carers as they attempt to do the impossible - fill the gaps, but at what cost?

(Mental Health Foundation ACT, Australian Capital Territory, Submission #256)

I am an NGO service provider – our surplus of funding from last year was taken from us by the Government without notice. The Government just doesn't think about the implications of taking away funding from NGOs. We already have long waiting lists and taking away funding makes them even longer. One of the young consumers who was on one of our waiting lists for four months was also caring for her mum – she killed herself because she felt she couldn't cope looking after her mum anymore without some support. Waiting lists for support from us have gone up from three weeks to four months.

(NGO Service Provider, Western Australia, West Perth Forum #29)

Police - the de facto mental health service?

When I turn up there and they are in crisis, I call the Crisis Assessment Team and they tell me to call the police! I want to know why I'm standing there alone and nobody is coming to help me.

(Carer, Mother, Victoria, Footscray Forum #1)

Even though they claim to be available 24 hrs a day/7 days a week through a 1800 telephone number, they are not providing a true 24/7 service... Currently, police are finding themselves being called prematurely and often unnecessarily to assist in the management of patients who have been released into the community or who are allegedly being treated while living in the community. They are also often being asked to retrieve AWL [Absent Without Leave] patients from the community without any attempt of the mental health teams to bring the patients back to hospital using their own resources.

(Police Association of New South Wales, New South Wales, Submission #59)

Where do people live if they can't get supported accommodation?

On the 6/8/04 my son rang distressed saying he had to have somewhere permanent to live if he had a CTO [Community Treatment Order]. Apparently it was suggested to him an alternative possibility would be a backpackers hostel. He asked to live with us again... Again whilst discussing suitable accommodation my son suggested he sleep at a friend's on a couch. I told the nurse this was not an option. My son then suggested sleeping in his car, something he did for periods prior to his hospitalisation. Again I expressed the belief that this is not conducive to his mental and medical rehabilitation. I was taken aback at her suggestion that living in the car is an option, it is an alternative lifestyle that some people like. This I believe is not an option for a vulnerable person in Australia in 2004. We have seen no evidence of my son being able to function alone.

(Carer, Mother, South Australia, Submission #11)

Prisons – the new institutions for people with mental illness?

The prison system is not the place to provide care for those with a mental illness. My work and the work of others has shown that many people who end up in jail do so as a result of not being able to access a mental health service. In many cases you will find it is deemed to always be the fault of the individual if something happens. We need to know why the services are never ever held accountable for failing to provide care?

(Consumer Advocate, Victoria, Footscray Forum #9).

What progress since Burdekin?

After 30 years of social work practice I've entered many SRFs [Supported Residential Facilities] - starting in 1970s. I can confidently say that the Burdekin Report made absolutely no difference to the lives of these men & women, most of whom experience mental illness. Their level of physical & mental health is at the same disastrous level as homeless & Aboriginal people... Going into some of the Facilities today, I feel like they are in worse shape than in the 1970s when many were established at the encouragement of the government to "empty out" the back wards of the psychiatric hospitals. And talking with the managers, it's clear that they do not feel that they and their residents are receiving anywhere near an adequate service from the mental health services.

(Family Member and Service Provider, South Australia, Submission #34)