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# LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION COMMITTEE 'A'

## SUB COMMITTEE INQUIRY INTO HEALTH SERVICES IN TASMANIA

**Submission written and authorised by Alan Churchill** Wednesday 19th July 2017

**OPENING:**

I have no academic qualifications. However I hope that the Committee will accept my long hands-on experience as a carer which began as early as New Year January 1956 as my qualification to make this submission.

At that time my late wife Valerie displayed first symptoms of ill mental health (later diagnosed as schizophrenia) after which I became her carer until March 2010 (a period of 54 years) when she was placed in the May Shaw facility at Swansea where she passed away 10th August 2011.

During those years Valerie was periodically placed at every mental health institution in Southern Tasmania for rehabilitation.

Since then until the present time I have been carer for a woman who has a history of schizophrenia which is controlled by medication. Adding the past seven years, that makes a total of 61 years, arguably making me the longest serving carer in Tasmania and possibly in Australia.

It is my serious opinion that such a long period as a carer for mentally ill patients should adequately qualify me to contribute to this inquiry.

It is my firm conviction that actual hands-on experience can be as valuable as that of academia in full understanding of such care, its impacts on the health of carer, as well as significant benefits to those receiving the care and importantly, the recognised savings to the National economy.

**TERMS OF REFERENCE:**

1. **Current and projected state demand for acute health services:**

   While I am aware of current shortcomings in health care within the state I feel that I am not qualified to comment on this issue other than to say that the need for an urgent review of health services leading to introduction of suitable improvements should not be delayed.

It is obvious that with an ageing population (and a growing one) the need for futuristic thinking on areas of improvement will become more acute and more necessary with each passing year.

2. **Factors impacting on the capacity of each hospital to meet the current and projected demand in the provision of acute health services:**

   I am not qualified to respond on this issue.

3. **The adequacy and efficacy of current state and commonwealth funding arrangements:**

It is evident that both commonwealth and state governments have been compelled to make significant savings in all portfolios.

However effective health care, being an essential need in our communities, should not be further restricted by additional cuts to expenditure.

Already some medical spokespersons have publicly stated that surgeons, nursing staff and mental health professionals are working under severe stress, which is in itself a significantly unsustainable situation in relation of provision of good health outcomes.

Effective health care should be driven by need, not by budgetary constraints.

4.

**The level of engagement with the private sector in the delivery of acute health services:**

Provision of a suitably high grade of health care is unquestionably the responsibility of both state and commonwealth governments. These responsibilities must be well defined in regard to which level of government holds responsibility. Examination of possible (or additional) inclusion of the private sector is a worthy path to pursue.

However it must be recognised that the private sector needs to make a profit to participate.

Therefore government subsidies would be required to enable said profits because without them, costs would be far beyond resources of ordinary individuals.

Final mutual agreements between participating organisations and government would need to be arrived at before implementation.

5.

**The impact, extent of and factors contributing to adverse patient outcomes in the delivery of acute health services:**

Judging by regular media releases relating to inadequacies of existing administration, irregularities, understaffing etc., Tasmania's hospital system is currently failing to provide a level of health care not only for patients but for medical professionals themselves (especially surgeons).

For example a report in the Mercury Saturday July 15th 2017 (reporter Natasha Bita) tells us three quarters of surgeons and intensive-care specialists are on rosters that put them at risk of fatigue with one surgeon said to have worked an incredible **76 hours** straight. (The apparent impossibility of this figure casts

doubt upon the authenticity of this report) According to a survey by the AMA five yearly Safe Hours Audit, the average hospital shift, including overtime is from 12 to18 hours per day. Some hospital doctors are working as much as 118 hours a week while a typical 78 hour week places them at risk of fatigue. These figures apply across the nation, so we can safely say that the Commonwealth government is clearly responsible for this shocking state of neglect.

It is safe to suppose that Tasmania's hospitals are struggling under similar dangerous conditions as those across the nation.

Careful consideration should be given by this inquiry into shifting of responsibility from Commonwealth to State governments, especially where the former fails to provide adequate funding to the latter to maintain an acceptable level of health care.

But it is not in hospitals alone that insufficient levels of patient care exists.

Out in our communities there are huge numbers of elderly, physically and/or psychologically handicapped people, most of whom are marginalised by the current "system." Virtually all of these people, clearly disadvantaged in comparison to those who have good health, are in urgent need of varying levels of help.

One reason why the people I speak of are overlooked and neglected is that attention of governments is almost fully occupied by the hospital system which daily falls under scrutiny of the media.

There is little publicity given to handicapped citizens who have "fallen through the cracks." The public is led to believe that these folk are receiving top quality health care. From my personal position of long term caring at coal-face level I now understand that this belief is false, especially now that I myself need help.

I feel it necessary that this inquiry should navigate through the complexities of our current failing health system, resulting in a positive outcome, one that will recommend obvious improvements and more importantly, one that will be acted upon.

Too many reviews and inquiries made at governmental level by dedicated committee members are shelved for future consideration, only to be quietly shelved and forgotten. This inquiry should not suffer that fate.

**6.**

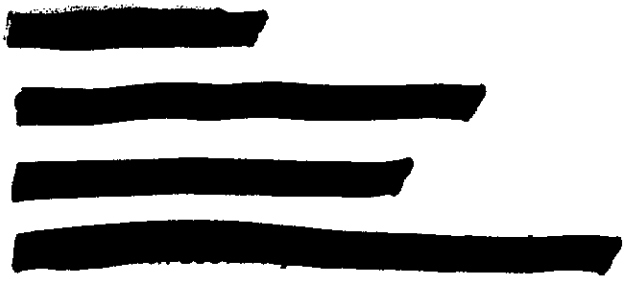
**Any other matters incidental thereto:**

Rules of most reviews or inquiries do not encourage personal input.

However in this instance I have taken the liberty of outlining three accounts that are of a personal nature. I have not given any names (other than my own) to protect those who are mentioned in the three separate documents and leave it to the discretion of the Committee whether or not they should be included in this submission.

How else I ask, can a Committee of investigation arrive at an **all-encompassing** final report, without first-person, true life-accounts of existing areas of concern?

**Submission by Alan Churchill**



# Document 1 of 3

At the age of 64 when I retired from the workforce in 1997, I began to notice that my left foot was losing feeling, causing my foot to slap down with each step. The condition worsened until around 2010 when I began to feel pain and loss of feeling in my left foot.

Try as I might, I could not walk normally without some pain in the left hip, lower leg and foot. This in no way precluded me from activities such as bushwalking, cycling and kayaking etc. At that time my GP at the Eastern Shore medical clinic at Rosny advised taking over-the-counter pain medication.

Until mid-2016 I experienced little inconvenience from the injury, even after working for a full day in the bush on a chainsaw. My injury was supposedly caused by my falling over a cliff around 1965.

I began to experience almost complete loss of feeling in the left foot in early 2016. On three occasions while shopping I actually fell over and was helped up by concerned passers-by. Because of loss of feeling in my leg and foot and mainly the embarrassment of falling, I consulted my current GP at the Glenorchy Medical Centre.

Tests and x-rays determined that a sciatic nerve in my hip was pinched, causing my worsening disability.

I was informed by my GP in May 2017 that an operation could be expected to deliver only a 50/50 chance of improvement. For that reason I decided not to have the operation.

However, even though I am still able to continue with my duty of caring for the lady with whom I am boarding and to do shopping etc. I am on strong medication to subdue the pain sufficiently to sleep at night. The place where I live is hilly and precludes the use of a mobility scooter that I intend to buy in the near future.

Maintaining the garden that I took pride in is now beyond me.

Walking is becoming more difficult although driving is no trouble. I feel confident and relaxed while driving, but one cannot drive within shopping malls. I also feel quite able to carry on with my caring duties as at present except that I will no longer live at the same premises.

For these reasons I decided to apply to Housing Connect for accommodation in an area that is more level and close to amenities, thus enabling me to use a mobility scooter.

In order to apply for housing I am required to complete a document stating my circumstances and reasons for this action.

Naturally because my GP had been treating my condition for many months, it was to him that I turned to fill out the document.

I was dismayed to see that the GP had stated that my primary reason for seeking housing was that I was sensitive to neighbourhood noise and that he was not aware that impacts of noise was a medical or psychological diagnosis. This was immediately after I had spent many minutes explaining my reasons that are outlined above in this document.

Rather than helping, the input from the GP would almost certainly deny my chance of gaining suitable accommodation. Upon further advice from Housing Connect, I resubmitted another document to my GP on which he again said that my **primary** reason for requesting alternative housing was because of **hyperacusis,** a medical term for intolerance to excessive noise.

On both occasions the hyperacusis is a secondary reason. It is puzzling that after two consultations the GP persisted with hyperacusis being my primary reason for the application for housing. That is **incorrect.** My **primary** is by far **my reduced ability to stand on or walk with my foot that has lost sense of feeling.**

In addition elderly and/or incapacitated people are told by many public servants to go here, go there, phone this person or that person. In other words they are saying "We can't help you. Do it yourself". This is regardless of capacity of those seeking help, because of their disability, to do so.

In this respect we face a dilemma that can often turn into despair, and utter despair can lead to thoughts of suicide as a final solution. Deep despair with no apparent prospect of relief is a catalyst for suicidal thoughts.

(Please understand that I myself do not and never will harbour thoughts of suicide)

There is much room for improvement in the area of uncertainty and not knowing where to turn for the general public and especially for those who suffer from mental illness.

We need one central authority that can advise those who are in urgent need of making the right contacts to address their own particular avenue of enquiry.

Alan Churchill

[redacted]

Document 2 of 3

# A CASE OF LONG MENTAL HEALTH DETENTION

In early September 2009 a mental health intervention team was called to a residence in Glenorchy Tasmania following a plea from a distraught mother to take control of a son then aged 20 years who had become difficult to control and had refused to go voluntarily to the RHH for assessment of his mental health condition (schizophrenia).

Shortly after the team arrived they walked out of the home saying there was nothing they could do. Then they left. This posed for the mother a serious dilemma. Should she attempt to calm the son or call police? Having had experience with cases of schizophrenia (and incidentally having experienced the same illness herself) and fearing personal violence to herself should she attempt intervention, she correctly called police.

When many police officers attended, the son, being frightened by the confrontational attitude adopted by arresting officers, grabbed a kitchen knife and ran from the home. Police chased him down the driveway with one female officer levelling a pistol at his back while the mother pleaded with her not to shoot.

The son ran across the street where police officers knocked him to the ground. During the following melee the son stabbed one officer three times with the knife and another officer then bashed the son's face on the kerbing, breaking his front teeth. Then, following a violent arrest, psychiatrists had the son placed in the Wilfred Lopes Centre (WLC) where he remains to this date, a total of 7 years and 9 months.

During that long period of detention his mother continues to grieve for him and his dilemma which she partly blames upon herself, regretting her action of calling police on that night so long ago.

As the mother's current carer I am acutely aware of the way in which the events described occurred, followed by the futility of all our attempts to gain freedom for the son from the WLC. This is is adversely impacting on the mother's health both mentally and physically. Although being a good driver she rarely leaves the home spending all day and every day in bed. She has developed an impulsive eating disorder and become a type 2 diabetic.

I personally have succeeded in being accepted as a representative for the son at sittings of the Mental Health Tribunal where I am given respect by the Tribunal and am given opportunity to speak on behalf of the son and the mother. I deeply appreciate this.

Recently I heard on the radio that the programme director and the announcer were aghast that a family member had been detained at a similar institution to WLC in NSW without charge for ten years.

In the case outlined in this document the son was charged in the Supreme Court with assault and found not guilty on the grounds of temporary insanity.

There is every indication that the son's mental condition is well controlled by medication --- but--- the final decider rests with the opinion of the head psychiatrist at WLC.

At each sitting of the Tribunal, year after year, the psychiatrist advises that he does not consider the son ready for release. The tribunal is then restricted to the only possible finding, that the son remains at WLC for a further twelve months, ad infinitum.

I often visit the son who appreciates the Christmas cake and Birthday cake that I insist on taking him every year (often with begrudging consent of WLC staff).

My personal opinion is that primary motivations of successive psychiatrists, when determining whether or not the son should be released, are being influenced by possible adverse impacts on their own professionalism, should the subject re-offend, rather than on the welfare of the subject.

The young man referred to in this document was, as a child, a quiet docile boy who enjoyed his mother reading to him until he slept and who later in his youth became adept and certainly above average with computers. He capably held down a job where he was required to handle money and to liaise with the public.

As often happens following cases of extreme personal trauma the son appears to have expunged the happenings of his arrest and the stabbing of the police officer from his memory and he refuses to acknowledge that he has a mental illness. Could this be sufficient grounds for his continued detention while he clearly shows an ability to live in the community under medication as he is currently doing?

Incidentally I believe the Mental Health Act says that a detainee must, before final release into society, first undergo a period of living in a separate facility for a period under strict supervision to ensure that medication is taken as necessary. At the latest sitting of the Tribunal in June, the Head Psychiatrist mentioned that no such facility is exists in Tasmania.

It is my conviction that a person who is incarcerated for endless years must assuredly become more unable to adjust to normal living in the community.

A lengthy period of confinement robs the subject of ability to make personal decisions, of opportunities to mix with other people, to take part in normal conversation and of personal dignity. All of these things are needed in order to live normally, thus further deteriorating an already dire situation.

**QUESTION:**

Could this board of inquiry consider discussing training some police officers specifically to take mentally ill people into detention using persuasion and understanding to replace the current regime of bludgeoning these unfortunate individuals into submission?

This has a potential of saving significant governmental expense that is always associated with lengthy periods of detention while minimising the suffering, heartache and further deterioration of the health of both the arrestee and family.

Document 3 of 3

# THE FATE OF THE NATIONAL MENTAL HEALTH COMMISSION REVIEW.

I am an early submitter to the National Mental Health Commission that began its deliberations in January 2012 and ended its report in October 2016 when findings of the Commission were passed on to state and territory governments for implementation.

Since then, apart from occasional media reports and vague statements by government spokespersons, the general public and especially those who share a common interest in a clear path to implementation of recommendations arising from the NMHC report, are given little hope for improvement.

The NMHC was set up at great expense by expert mental health professionals in conjunction with the Australian government to urgently address the failure of mental health care at that time. The resultant report was time consuming, all-inclusive and thorough.

Now, over six years later there are virtually no changes apparent to the way in which mental health care has improved across the nation.

The excellent work undertaken by dedicated members of the NMHC should be seen as an event of a century for all those who have hoped that long-awaited reform in mental health care would eventuate. Those whose daily lives are seriously impacted by the complexities of mental ill-health in all its forms have expected significant improvements arising from the NMHC report.

Because mental health currently has at least some effect on members of the general public, it would be indeed insufferable if the findings of the report were to be quietly allowed to fade into oblivion, as has been the fate of many other reviews in the past.

I ask that Administration Committee 'A' become familiar with the findings of the NMHC final report with an aim of not allowing state governments to allow responsibilities to lapse because of lack of funding.

Good mental health is equally as important as good physical health and I venture to say, even more important given the secondary attention that has prevailed regarding mental health until the advent of the NMHC report.

**One subject of my submission to the NMHC in 2012:**

In the case where arrest of mentally ill people by police officers becomes necessary, improvements should be implemented. Police officers are not sufficiently trained in techniques of arresting mentally-unstable subjects and commonly respond to violence with more violence. This is a natural phenomenon but to "come heavy" on a person who is suffering from paranoia will invariably result in an equally violent reaction. This can endanger lives of both arresting officers and arrestees. It is by far preferable for suitably trained arresting officers to have special training in persuasive and non-threatening procedures.

*An instance of an arrest procedure that went wrong in September of 2009 resulted in a police officer being stabbed three times in the back with a kitchen knife and the person being arrested having his face bashed into a gutter curbing, smashing his front teeth. Following the arrest that occurred in September 2009, the person being arrested was placed in confinement at the Wilfred Lopes Centre where he remains to this date. Because the Head Psychiatrist is unwilling to give this person a chance the Mental Health Tribunal is obliged to keep him imprisoned for almost 8 years. The determination of the Tribunal in June of this year was another twelve months in detention, the same as in every year since 2010. Had a suitably-trained arresting officer attended the original call for assistance, it is possible that the person I refer to would still enjoy his liberty and could be leading a contributing life.*

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