

Consultations with consumers and carers about psychiatrists' roles in Australia's mental health systems

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1. Introduction

1.1 Prologue

This paper reports the collective wisdom of some 102 people who, to varying degrees and in different ways, have had contact with the mental health system. Their names are recorded in Appendix 1 to this document, and I would like to begin by expressing my extreme gratitude to them for the trust and honesty they showed in telling me their stories. I know the value I place on my own personal story, and I assume others do the same. I hope they knew just how much I valued what they let me record, and know that I have taken seriously the task of trying to do so accurately.

The release just within this last month of the Human Rights Commissioner's report revisiting the Commission's previous survey of the situation of people with psychiatric disabilities has refocussed attention on the area, and highlighted once again the fact that the task of "getting it right" in the provision of mental health services remains a national priority.

In this context, I was also acutely aware of the difficulties of the "flying visit": the consultant who arrives with never enough background on the local reality, always trying to put things into the "bigger picture", perhaps a little insensitive to the salience that local experience gives. I can but acknowledge the difficulty. The warmth with which I was welcomed witnessed to people's desire not to let it impede our discussions. I tried to learn as I went. Thanks in this regard are especially due to Ray Bromley and Jan Ford, Kylie Fung, Shirley Wilson and Tina Hatchett, Mike Fenton, Karen Aucote, Moya Newman, Nick Green, Betty O'Halloran, Ethnee Shields, John McGrath and Libby Steeper, the people who helped put groups for me to talk with together.

It would be fair to say that for most of the people I met with the mental health system has been a mental illness treatment system. And indeed one of the warming parts of being able to conduct the consultation was to see the way that consumers and carers are actively seeking opportunities to become proactive advocates for one another to try to build an even more holistic and humanly sensitive approach to care and prevention.

It was a very humbling experience to have the chance to speak frankly and forthrightly with people who have often suffered much. They have suffered because of the dislocating impacts of psychiatric illnesses themselves, but also because of the way the community as a whole has often misunderstood their illnesses and their needs, and the way the health system has, I think it is fair to say, often disempowered them (albeit sometimes for very humanitarian reasons, or because of unrealistic resource pressures).

At the same time, there was something immensely ennobling in this experience for me: I met people who had chosen to be agents where the pressure was to remain victims; I saw great signs of hope and growth in the solidarity that consumers and carers were able to build; sometimes I even saw signs of that healthy conflict of views that appears when people begin to feel confident enough with one another's commitments to begin to quibble about the details!

1.2 Context

Psychiatrists are a key component of the mental health workforce. As a result of their extensive training, they have unique skills and expertise in mental health and mental illness. The Commonwealth Government commits a significant proportion of the health dollar it spends on the mental health system to funding psychiatric services, both through the Medicare rebate system, and as a component of the Commonwealth/State health funding

agreements. It is important that their relatively expensive skills are used in the best way to assist people with mental illness.

Bernie McKay & Associates were commissioned by the Commonwealth Department of Human Services and Health to look at the way psychiatrists' services are supplied and to suggest better ways of making use of these services. The objectives of the project included determining:

- what types of psychiatrists work where;
- how this impacts on consumer access to support and how this influences access to professional advice;
- whether work practices of psychiatrists differ in public and private practice;
- how well services are placed to meet needs;
- whether services are supplied economically and usefully; and,
- what factors influence the current way services are provided.

Bernie McKay & Associates have worked closely with the Commonwealth Department of Human Services and Health, State and Territory authorities and their Mental Health services, professional medical and allied health bodies and representatives from the National Community Advisory Group, to collect factual information about where psychiatrists practice in Australia, the number of public and private patients they see, and how different types of services are funded.

To ensure the consultation process would be comprehensive, a series of structured group interviews with focus groups of consumers and carers assembled by Consumer Advisory Groups in each State and Territory was undertaken to hear and report on their views about services provided by psychiatrists. The aim of this process was to document how the present system affects consumers and their families. This paper reports the results of those consultations.

2. Methodology

2.1 The Groups:

Preliminary enquiries indicated that different groups in the community may have different experiences of the psychiatric service system. For example, carers often make first contact with mental health services, and may have quite different needs at that time from consumers seeking long term support. Agencies that regularly have contact with people with psychiatric problems may find different problems helping people access services than carers or consumers themselves do. People who do not speak English easily may experience difficulties that English speakers do not. It has been suggested that the needs of young people experiencing their first psychiatric episode may be unlike those of people with long term conditions requiring maintenance, or that people with multiple disabilities can have more difficulty accessing a suitable mix of services. Similarly, the obvious differences in service distribution in the cities and in remote areas suggests that people in remote or rural areas may have special difficulties with the present system. Given the short time for organising the meetings and that the focus groups were composed of between about 6 and 12 people, it was not feasible to have a "representative" of every possible group mentioned above at the meetings.

Nonetheless, those who did take part were drawn from a broad cross section of consumers and carers Australia wide and were able to address themselves to any special needs like these, as well as evaluating the service system as a whole. The gender of those who took part is shown in Figure 1 below:

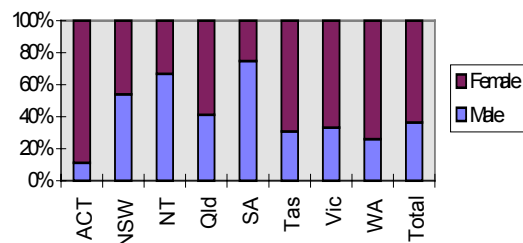


Figure 1: Consultation on role of psychiatrists
Gender of participants

The age groups of participants is shown in Figure 2:

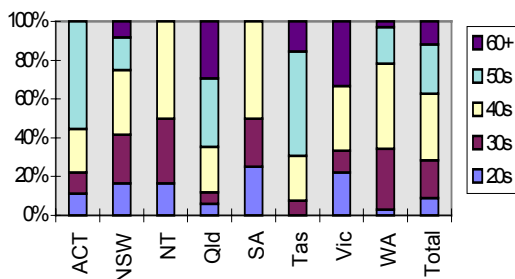


Figure 2: Consultation on role of psychiatrists
Age groups of participants

It was not possible given the time frame for the consultation to cover all parts of regional and rural Australia. Nonetheless, there was an extensive attempt to consult people in Western Australia who might be able to throw light on any special issues that emerge in these contexts. 12 focus group consultations were held in the following locations, with the following numbers of participants:

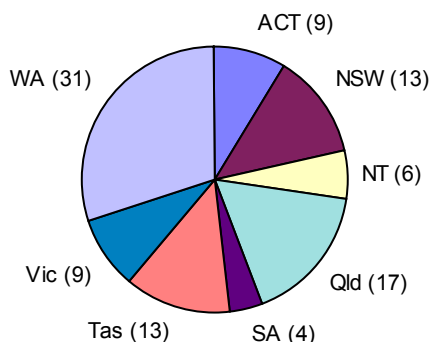


Figure 3: Consultation on the role of psychiatrists
Participants by location

Focus groups were made up of consumers, carers and people from service agencies in proportions as detailed in Figure 4:

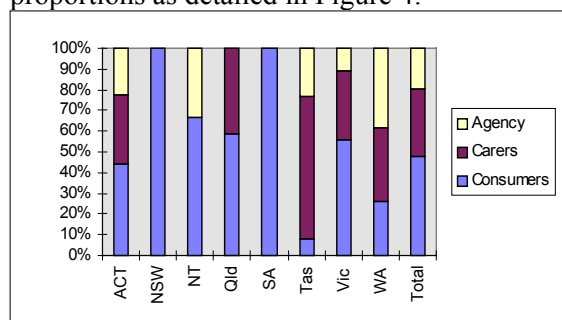


Figure 4: Consultation on role of psychiatrists
Proportion of consumers, carers and agency staff in groups consulted

Meetings were held in all capital cities, and in Western Australia and Tasmania, more extensively in order to try to capture a view of the specific situation in rural and more remote areas. Two of the meetings took place with groups assembled by the local Aboriginal Medical Service.

The focus on Western Australia proved very useful in providing information about how psychiatric services are delivered to Aboriginal communities, and in understanding the particular needs of carers and consumers not in major metropolitan or provincial areas. Some caution must be used however in generalising from the Western Australian experience because an historically much more centralised service provision system than that found in the other States and Territories needs to be considered in reckoning the tenor of responses. Indeed, the Western Australian consumers and carers were themselves highly critical of the system of transportation of severely ill consumers to Perth for treatment, and their concerns lead to one of the major systemic conclusions of the report about localised services that may not be as imperative in other parts of the country.

2.2 The Questionnaire

Prior to the focus group meetings, group convenors were sent a project brief substantially in the terms of the *Introduction* above, and the following list of questions which were to form the basis for discussion:

“The consultation process is meant to be open ended and the questions below simply try to focus the discussion a little:

1. *How do people get appointments to see psychiatrists?*
 - *Is it easy and quick?*
 - *Where are difficulties experienced and why?*
 - *What is likely to make it quicker and easier?*
 - *What happens in emergencies?*
 - *Or out of normal working hours?*
 - *Do people normally get the help they need in good time?*
 - *Who misses out on efficient service at present?*

1. *How do people with appointments get to see psychiatrists?*

- *Are services conveniently located?*
- *Is the system flexible enough?*
- *Do they get to see them soon enough and often enough?*

3. *How satisfied are consumers and their carers with the actual services provided by psychiatrists?*

- *With consultations?*
- *With the education provided about their illness?*
- *With treatments?*
- *With the attitudes of psychiatrists?*
- *With communication between psychiatrists and GPs and other health professionals?*
- *With the links between psychiatric services and other community supports?*
- *With the liaison between the police and psychiatric services?*
- *With the cost of services?*
- *With communication between the public and private sectors?*

4. *What parts of the system for getting psychiatrists' help work well?*

5. *Where are the greatest needs for improvement?*

- *From a user's perspective?*
- *From a carer's point of view?*
- *From the aspect of other service agencies?*

The consultation process is not intended to be a witch hunt; so if any specific incidents are mentioned during the consultations the persons involved should not be identified, and, if they are inadvertently mentioned, they will certainly not be recorded in Terry Laidler's final report."

2.3 The Analysis

The original intention had been to provide some form of quantitative analysis of the replies to the five basic questions. This did not prove possible for a variety of reasons.

First, from a consumer and carer perspective, it very quickly became clear in the consultations that it is not feasible or useful to separate out any one component of the care system, including the role of psychiatrists. In fact, it is most frequently the very interaction of components of the system that is the best predictor of consumer and carer satisfaction or dissatisfaction.

Consequently, consumers and carers, while using the questions as a departure point, were almost universally more comfortable with episodic and historic narrative approaches to making their contributions.

Secondly, it is very difficult to generalise about the "role of psychiatrists". The stories told were incredibly mixed and much of their piquancy derived from the personality and skill of the personnel involved.

Thirdly, in the main, participants in the consultations gave a strong sense that it was important to "ground" evaluation of the service system and policy development options. There was a strong feeling that while much has been achieved with psychiatric services over the past fifteen or so years, significant amounts of the achievement had been at a conceptual level and had not permeated the service system attitudinally and practically. As one participant put it:

There has been a lot of talk, a lot of consultations and a lot of studies, but the food in the kiosk at the hospital is still expensive and (poor), and it's still the most boring place to be locked up in.

The approach adopted, then, was that reported below: a short summary of key matters arising from each of the consultation's meetings is provided, as is a more general overview of recurrent themes that emerged from the discussions. Some of these recurrent themes refer very directly to psychiatrists, their training and their current and optative roles in the mental health system. Some are more of the order of system wide issues which by their very nature impact on the work of psychiatrists.

3. Reports of specific meetings

The reports provided below are in no way intended to be transcripts of the meetings held. They were compiled from brief notes taken at the time of each meeting and are intended to give a flavour of the meeting in question as well as indicating the main themes that were canvassed therein rather than reporting individual comments verbatim. Further, the reports were compiled within hours of the meetings themselves to ensure freshness of recall, and this is reflected to some extent in variations in style and some repetition.

3.1 New South Wales

The major problem reported was the length of time taken to get psychiatric assistance. This varied from area to area, but perhaps surprisingly, not greatly from sector to sector. While the waiting time for an initial appointment was often of the order of months, the problem was immense in rural areas, where sometimes waits of up to 8 months were reported.

Consumers felt that service users could roughly be divided into two groups: those whose illnesses (and sometimes treatment) had so affected them that they found it difficult to be assertive and to take some control of their treatment got less expedient treatment, and worse service, especially in terms of knowledge about their illness and medication, and choice of psychiatrist and other services. More assertive consumers had less trouble exercising choice of practitioner and generally expressed more satisfaction with the quality and mix of their services.

The importance of networks in gaining access to psychiatrists' services was another main focus of discussion. Various participants (all consumers) spoke of the relative ease with which they now accessed psychiatrists compared with the earlier stages of their treatment. The networks and intermediaries varied (case workers, service agencies, GPs or direct contact) but there was little doubt in their view that contact breeds ease of contact.

At the same time, they spoke of the inequity for new users of long waits, short consultations, use of medication without

explanation and a general inability to get assistance in emergencies. One consumer wondered why psychiatrists did not keep some specific times free to deal with emergencies, and why they insisted on consumers going to them rather than in some instances being prepared to go to consumers.

F**k all education is provided about one's illness especially in regards to medication one is being prescribed. Alternatives are not offered as an option. Consumers get sick and tired of the medical model. The psyche simply pulls out a prescription pad rather than really talking to the consumer. Some psyches say straight out "I'm a drug man" — they believe medication holds all the answers.

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You can wait anything up to 3 months to see a private psychiatrist when you first make contact, and what's worse, if they're any good they're flooded and their books will be closed.

There was agreement about the value of 24 hour counselling lines which each consumer

seemed to have used at some stage or another. Participants felt there was some need for a dedicated psychiatric service of this type.

The concept of community based crisis intervention teams received good support, but the need to resource them adequately was stressed:

I rang the crisis intervention team for my flatmate because I knew he was a bit manic. They said they were too busy to come but asked me to put him on the phone. When he spoke to them, they asked him to come into the hospital for an assessment. Of course, he didn't.

What is viewed as collaboration between service providers by the mental health system is sometimes seen as collusion to restrict choice by people with psychiatric illnesses. As one consumer put it in a written submission:

Some "share care" programs want the GP, the Health Worker, the Relative and the Consumer all in the same room together. This is a power play where the consumer's voice will be hard pressed to be heard in (sic). Three power brokers and one consumer.

It was in this context, that participants stressed strongly the need for well funded advocacy services as well.

3.2 Queensland

While there was lively interest in the questions under discussion, the group felt that much time had been spent in the past decade on consultations and consultants, but that insufficient had been achieved in terms of genuine and substantial improvements to the general service system.

Queensland consumers report two quite distinct sets of experience dependant upon whether they live in urban or rural and remote areas. While consumers in city areas have very serious concerns about the quality of services, the range of choice open to them, and the way

they are treated within the psychiatric system, consumers in rural and remote areas have enormous difficulty in many instances even getting treatment from a psychiatrist.

The need for continuity of care was a central theme in discussions, and the particular practice of not allowing private treating psychiatrists to continue treatment when their patients were admitted to public facilities came in for much criticism.

It was strongly argued that immediate attention needed to be given to the issues surrounding the provision of psychiatrists' services in correctional facilities. Carers and consumers who have had contact with the corrections system believe that the prison population has substantial numbers of people with psychiatric disability and substance dependence in its midst, and yet the practice of forensic psychiatry is currently limited by what sometimes appears almost whimsical decision making by correctional staff about access to psychiatric services and treatment regimes. It was also suggested that there is very little follow-up between corrections psychiatrists and the more general system for prisoners who are released.

No-one should proceed through the criminal justice system without some "risk assessment" procedure being implemented not just when their condition affects their plea, but in all cases.

There was significant concern expressed about recent references at bureaucratic and political level to the "worried well". Consumers and carers were unanimous that it fed popular misapprehension to talk in this way, because it is clear that the absence of hallucinations, delusions or other psychotic behaviour is no indicator of mental "health". For example, many confused or even suicidal people who are nonetheless in need of professional health do not exhibit these symptoms. The lack of recognition and funding under Medicare of the work of psychologists and others trained in cognitive and "talk" therapies is part of this problem. It leads to psychiatrists, sometimes with no special skill in these areas, over attending to people with this level of

dysfunction, but not readily available to do that for which their training most equips them, managing extreme manifestations of psychosis.

There was a significant emphasis in the group on the need for ongoing exposure to consumers and carers in training and maintenance programs for people whose work brings them into regular contact with people with psychiatric disabilities. Foremost amongst those mentioned in this respect were psychiatrists and mental health workers, but discussions also emphasised the same need for police officers and ambulance staff.

And it was argued that consumers and carers should be active participants in all aspects of the service systems: in advocacy and support groups, in crisis intervention teams, and in treatment programs, both for the assistance it will provide and as a further way of empowering them in a system which has traditionally devalued them and their experience.

The lack of sensitivity of the generic system to the special needs of some groups in the community was commented upon. Women (especially when dealing with matters related to sexual abuse), homosexual people who have a lingering suspicion that their sexual preferences are still regarded as an “illness”, people from different cultural backgrounds especially where English is not their first language, people whose religious background is important to their whole well being, and expressly Aboriginal and Torres Strait Island people often feel that their cultural and personal frameworks are not taken into account in planning treatment regimes. It was recognised that it was implausible to have psychiatrists in every locality from every possible group represented in local communities, but questions were raised about the adequacy of the treatment of cultural sensitivity in psychiatric training.

3.3 South Australia

Many of the themes taken up in previous meetings were reiterated, especially those concerning difficulty in making first contact with the system, poor access in crisis situations, and the need for assistance and

advocacy in “shopping around” for a good psychiatrist or mental health worker for long term care.

There was also a discussion of the impact of mainstreaming on the quality of psychiatric care with a clear impression among some consumers that psychiatrists are often the “poor cousins” and lose out in competition for hospital resources.

The importance of current and future public education campaigns was raised with the comment that while the present National Mental Health Strategy campaign which focussed on the workplace and the general community was good, it should also direct some of its resources to family education. The importance of family support generally was also a point of discussion, and the difficulty for psychiatrists in balancing the demand of patient confidentiality with good communication with carers was noted. It was felt that in the main what carers wanted was reassurance that they had been listened to rather than to be told things, and that consumers should be involved in decisions about who information should be communicated to.

The use of tele-psychiatry being trialed presently in the state was remarked upon and generally felt to be of some likely assistance in relieving the pressing needs of people in remote areas with psychiatric disabilities. Similarly, the development of community mental health teams met with approval but also with a concern that there was too little being provided in too few areas with too limited access hours. The tendency for the public system to screen for the “seriously mentally ill” notably in decisions about access to case management was referred to unfavourably in this context.

Psychiatrists were viewed as fairly poor educators of consumers and carers about the nature of psychiatric illnesses and proposed treatment regimes. They were also seen as poor at putting consumers and carers in touch with other sources of community support. Their absence in the main from community education campaigns was remarked upon especially to the extent that it was believed that

their involvement was important to the credibility of such campaigns.

The importance of involving consumers and carers as more than patients and their relatives in psychiatric training and in-service training was highlighted, and mention was made of similar involvement in training of GPs, police and ambulance officers.

Difficulties consumers had in securing continuity of care because of high turnover in the public system and because of the lack of involvement of private practitioners with community support structures was a key element in the discussions.

3.4 South West Western Australia

The particular problems establishing continuity of care in areas served by visiting psychiatrists, and the difficulty in getting any form of regular or emergency access in these situations was a key point in the conversation. Because of this, the lack of local acute mental health care beds, and the only very recent development of community support teams, the local carers and consumers advocacy and support networks appeared reasonably highly developed if under-resourced.

The historical development of services in WA which had seen all acute mental health care places located in one centre in Perth was the source of extensive criticism especially because it involved removing people (and especially indigenous people) from their local communities and from their families who because of travel costs often found it impossible to be with consumers during times where family contact can be very important.

The bulk of the group were still highly critical of psychiatrists for being medication and side effect dominated in their therapies, and sometimes even demeaning of other useful supports and therapeutic approaches. There was direct comment about the need for more psychiatrists to develop holistic approaches to their care of consumers. This led to a dispute about the value of attaching psychiatrists to community mental health teams unless their attitude was such as to make them competent team members or leaders.

Some carers had experienced quite hostile reaction from psychiatrists, and even where less extreme, most reported feeling excluded from the care network when, because of their closeness to consumers, they often had very direct insight into the effects of treatments:

I found that the doctors would simply not listen to me - I got the impression that they thought I was just a silly little woman making a nuisance of myself. They made me feel guilty as if I was the cause of the problems.

The importance of adequate activities for people during times of recovery from major psychiatric episodes was stressed and the difficulty in providing this in rural and remote areas was remarked upon.

The lack of psychiatrists specialising in child and adolescent psychiatry was a major worry for the group.

3.5 Perth

Continuity of care was again a central theme of the discussion. But as one consumer put it what was required was not continuity at any cost, but continuity mixed with some real choice about which psychiatrist one could relate to, and with confidence in the relationship that developed. He hit on the slogan:

*Consumers want
CONTINUITY WITH
CONFIDENCE.*

The assumption that there was one thing called psychiatry practised with equal skill by most practitioners was challenged. Again, the need almost to screen psychiatrists until one found one who did not put too much faith in medication to the exclusion of other therapeutic approaches which involved counselling, activities and social support was stressed. The constant complaint was that it was difficult "to find someone to talk to".

If you're really lucky you might get a good psychiatrist

— but it shouldn't be a matter of luck.

It was suggested that much more use be made of psychologists, and certainly that there be some access to their services funded by Medicare, for people who had passed acute phases of their illnesses.

The over-representation of Aboriginal people at the state's main psychiatric hospital was noted, as were the difficulties this caused them because they had to be removed from their families and local communities to come to Perth for hospital treatment, and because, despite the good efforts of some staff, there appeared to be no special programs or services targeted to them.

Similar problems of under-resourcing of psychiatric emergency services were reported with one consumer reporting that the service had not attended on any one occasion in the last ten requests.

3.6 The Pilbara - Mawarnkarra Aboriginal Health Service

The main needs confronted by psychiatric services in the area come from disabilities arising from degenerative neurological disease in a relatively young population. The degenerative disease is precipitated by many of the same causes of indigenous ill health already well identified: diabetes, poor nutrition, alcohol and drug abuse, early onset cardiovascular disease, and child abuse.

The specific challenges facing community mental health workers who were the majority of participants in the discussion were seen as:

- *management of domestic needs of consumers (where they live, what they eat etc.)*
- *management of consumer behaviour in their home environment and wider community*
- *management of psychotropic medications*
- *provision of community education programs (both about general health*

issues and the specific needs of people with psychiatric disabilities

A similar stigma to that found in the general community attaches to mental illness in aboriginal communities. Because of this, even with good access to services, it was felt that people were not likely to self refer or be referred by family members. Access, then, depends on intervention by aboriginal health workers, and there are simply insufficient of them to meet present need.

Further, the resources (and especially the availability of outside expert assistance) at hand for the requisite community education are scant.

The current level of provision of psychiatric and psychological personnel is seen as poor, however there was some discussion as to whether monies that might be spent improving this situation could not also be used beneficially to address the shortage of aboriginal health workers. It was suggested that if such staff had cultural sensitivity, were good team players and could work in a holistic treatment environment they would be valuable assets. If not, then the question was indeed moot.

The continuing practice of removing severely ill people to the one centralised psychiatric facility in Perth for treatment was robustly criticised.

We believe in dealing with our people here. When they're sent to Perth, they're isolated. No-one tells the family anything about what's happening and they can't afford to travel there. You spend three weeks or so in there without community support. Backing and support is exactly what's needed. And often even the local doctor doesn't know what's been going on. But the local hospital can't take people who are very sick.

The need for GPs working in rural and remote areas to have good skills in psychological

medicine, and access to in-service training in this area was highlighted.

3.7 West Kimberley - Aboriginal Medical Service

Similar problems to those described in the Roebourne community with transport to Perth for seriously behaviorally disturbed psychotic people were identified, and the provision of some psychiatric beds at Broome Hospital was seen as a great possible step forward that would remedy the problem.

In the Kimberley context, the ability of any mental health practitioner to work flexibly and as part of a team was essential as was the ability to work with families and to take account of aboriginal spiritual and cultural beliefs. The use of financial packages to attract medical practitioners to rural and remote areas was questioned because it did not guarantee that the person chosen would meet these criteria.

Very practical measures that would seem to be easily taken would be of great assistance and yet seem difficult to achieve. These include a better alcohol and drug abuse service provision, access to HACC programs and the Disability Support Service.

Proactive and preventative programs which are vital to mental **health** were difficult to envisage because resources were so stretched simply responding to current needs to treat serious episodic **illness**. The level of post-crisis follow-up and community education vital to reduce stigma that was especially prevalent in small towns were similarly limited.

3.8 Northern Territory

Those taking part in the meeting gave clear indications that they believed that their mental health services worked in a fairly well-integrated fashion with good inter-sectoral collaboration and reasonable access to services even in crises. The main areas needing increased provision were in the area of alcohol and other drug related problems, and it was felt that aboriginal people and those away from population centres did not have equally adequate access to services. Some concern was

also expressed about whether people whose preferred language was one other than English were well served in the present structure.

There was agreement that the level of collaboration currently in evidence had not been easy, and that people had worked hard and continued to work hard to ensure services were co-ordinated. Nonetheless, the issue of continuity of care from psychiatrists and other members of mental health teams was again raised by consumers.

One of the many *Catch-22* situations that arises in the mental health field was clearly identified at the Darwin meeting. Compliance, that is people with psychiatric disabilities being prepared to follow medication regimes whilst in the midst of major psychiatric episodes, is a major issue in a lot of mental health treatment. It was pointed out that charging people (even at the PBS rate for Social Security beneficiaries) for medication they were already unwilling to take seemed to provide the wrong sort of incentive to them.

Regarding specific services provided by psychiatrists, consumers felt that the practitioners they dealt with were fairly good in the main but also reported fairly short consultations with specialists characterised as sometimes not “sympathetic” and “friendly” enough. It was felt that other mental health team staff often provided this type of support better, and more in accord with consumer wishes.

My doctor is mainly interested in my medication and doesn't go in for counselling much.

Sometimes I even get the impression that (he) just won't talk to me.

The importance of activities to people with psychiatric illnesses was emphasised both for those in hospitals during acute phases of illness but also more generally.

The food was terrible but the OT in the hospital was great and provided some relief from the general boredom.

activities are really important then and after.

Discussion suggested that mental health team staff members were often more alert to this need than psychiatrists. It was argued that psychiatrists training had not equipped them for the demands of working in the type of team environments that consumers found most helpful.

There was agreement that there needed to be much more consumer input into training programs for psychiatrists to redress what was seen to be an over-emphasis on biological approaches to the treatment of people with psychiatric disorders, sometimes at the expense of more holistic approaches.

3.9 Southern Tasmania

There was some concern expressed about this consultation process itself, and its focus on the workforce of psychiatrists. One member of the group called it:

...another example of "bitsy" planning for what are essentially systemic problems.

Some argued that many of the major problems in the provision of integrated services for mental health consumers were essentially bureaucratic with useful initiatives and better services often getting caught in inter-government, inter-departmental and inter-program ruts. The specific examples of people with dual disabilities where the disabilities were targeted by diverse programs were cited as the good case models of how things can go wrong.

The need for multi-disciplinary team approaches which offered supports across the range of handicaps and deficits that people with psychiatric disabilities suffer was seen as central to continuing improvement of the service system. The training and ability of psychiatrists to work in this model was questioned. It was argued that the basic skills needed by psychiatrists (and others in the service system for that matter) for work with consumers in such a context were what are generally called "active" listening skills. Some

felt that acquisition of these skills was so fundamental that it should be part of basic medical training.

This led to a fairly extensive discussion about the type and amount of training that psychiatrists receive, some question about its length, and some wondering about whether it really was good preparation for multi-disciplinary teamwork and for the important educative role they should play with consumers, carers, the medical profession and community at large.

The Health Minister's comments about private psychiatrists appearing to "spend too much time and taxpayers' subsidy looking after the worried well" were also high on the agenda. The group felt that the comments did not reflect their experience where better and more continuous care for severely ill people was to be had most easily in the private system. As one participant put it succinctly:

Dr Lawrence would do well to define the "worried well" — who does she mean? Are people with major depression, bipolar affective disorder, obsessive compulsive disorder, eating disorders, serious phobias, post-traumatic stress disorder, borderline personality disorder the "worried well"? If not, who is she talking about? The only part of her statement that has some truth is that the public system is providing inadequate attention for acute mental illness. Why is this so? Because public psychiatry has been chronically under-funded by governments since federation.

In this light, the group emphasised the need to begin to canvass preventative strategies in mental health, both because of the human tragedy that they would avert, but also because of the high cost of in-patient treatment for people who reach crisis points in their illness.

The absence of well tested, formal triage functions for access to private psychiatrists and to public psychiatric care was seen as a one

clear impediment to better and more efficient access to psychiatric care.

Carers spoke of what they believed to be the right of consumers to see their own treating psychiatrist when hospitalised in the public sector, and it was suggested that that patients of private psychiatrists should have access to public mental health support services in just the same way that private patients of other doctors and specialists have access to HACC services.

3.10 Northern Tasmania

Launceston, like Darwin, seems to benefit from the accident of scale that enables its psychiatric services to function, almost by necessity, as an integrated system. Participants felt that generally the system functions well with reasonable co-operation between private providers and the public system, especially its support services. The recent development of a community response team was seen to have been very beneficial, although there was some concern about its availability being limited to 11pm. The question of out of hours services for people experiencing their first major episode where they had not built a strong relationship with a service provider was seen as a continuing area of worry.

The main areas where there was seen to be a need for significant improvement in service provision was for people in rural and remote areas, and for children and adolescents. This was believed to be related to the more general difficulty of recruitment of specialists in Northern Tasmania.

In respect to the work of psychiatrists themselves, it was generally felt that their actual counselling skills were not uniformly good, and that time pressures often forced them to give insufficient time to consumers generally, and to post crisis counselling expressly. This pressure was also seen as the main cause of inadequacies in explaining to consumers and carers the nature of psychiatric disabilities and courses of treatment. It was also said that not all were able to strike the appropriate balance between client confidentiality and the need to listen to carers

and to keep them abreast of consumers' situations.

While some informal arrangements seemed to exist between private psychiatrists and public services, the general issue of consumers not having guaranteed access to private psychiatrists with whom they have established therapeutic relationships whilst in public facilities was again flagged.

3.11 Victoria

Early in the discussions, the desirability of consulting consumers and carers and the psychiatric profession separately as part of the present process was called into question. It was felt that the consultation may have been more robust if representatives of various groups had been together for discussions so that, from different perspectives, impressions of the current service system could have been tested against the experience of others.

The accountability of psychiatrists within the current service system was the underlying theme of much of the conversation. Within the public system, it was felt that there was an overemphasis on biological and pharmaceutical approaches to treatment. For example, the situation where people are "defined out" of the public system with "personality disorders" when they are found not to be amenable to quick stabilisation with medication was raised.

Within the private sector, it was felt that there were too few mechanisms available to ensure uniformly good standards of care. The assumption that standards of care are generally good was challenged. It was suggested that from a consumer perspective, it is very difficult even with significant amounts of "shopping around" to find a suitable psychiatrist who does not "objectify" the person seeking care, who is able to tap into other support mechanisms and networks, who keeps abreast of new developments in pharmaceuticals and who can deal, in psychotherapy with some or all over the personal agenda that people bring with their basic illness.

There was extended discussion of the profession's lack of public accountability for its training system. Issues related to the extreme length of the training program, the apprenticeship model with its insistence on systemic compliance, the use of people in training as "workhorses" in the public system were among those raised. One consumer summarised the tenor of these concerns:

It's like a club. They restrict the numbers who can join, and make it take a long time of working in fairly intolerable conditions. It's a power thing and they won't do anything that seems like it will lead to them losing their control. But the time has come for them to be accountable, to consumers and the community as a whole.

Concerns about implicit policy directions at the moment which view private psychiatrists as overpaid and not involved in the treatment of severely psychiatrically disabled people and those who use their services as over serviced were prominent. Given the level of contact with psychiatrists possible in the public system and their perceived over-reliance on biological models of care, it was argued that this might in fact be a way of ensuring, as one consumer put it, "bad care for all".

3.12 Australian Capital Territory

Discussion began around the theme of capricious and heavy handed decision making by some psychiatrists, especially in relation to getting first appointments to see them.

Some specific instances included consumers who were told they would not be seen on a bulk-billing basis because parents could afford to pay bills, the impossibility of getting appointments other than "on schedule", refusal to treat if a second opinion was sought, and only seeing bulk bill patients after 4pm.

You get the impression they (psychiatrists) know that they're in charge, and that they can do what they like.

When things get too hard, it's a matter of "get him put in an institution and forget him".

It was felt that psychiatrists in the main were not good at incorporating others into their decision making, be that consumers, their carers or other mental health professionals.

Examples were given of fairly innovative attempts by the ACT public housing authority to case conference in situations where a person's mental health needs impacted on their housing situation.

This was seen as an example of the sort of collaborative work best suited to serving the broad spectrum of consumer needs.

Doubt was expressed as to whether psychiatrists' current training equips them to work well in such an environment.

There's a lot more they (psychiatrists) will have to do if they don't want to be sidelined in the mental health system. At the moment it seems that they're not answerable to anyone.

The difficulty in getting a first appointment to see a psychiatrist was raised. It was pointed out that there was currently a wait of about 6 months for such an appointment, and a wait of up to 3 weeks for a non-scheduled appointment for a regular patient. This was related to a perceived shortage of psychiatrists in the ACT. It was argued that the ACT had fewer private psychiatrists per head of population than any other part of Australia (sic), no private psychiatric hospital and fewer public psychiatrists and that this needed remedy.

Some irony was noted about the relative ease, however, with which compensable patients appeared able to get appointments.

The problems in getting access to services out of standard working hours was discussed, and the anomaly of having to exhibit quite bizarre acting out behaviour even to get access to the services purported to meet this need was remarked.

The role of community nurses and other mental health professionals as advocates and gatekeepers was referred to, as was the advantage this represented because:

...they'll come to you. With psychiatrists, pretty well always you go and see them. I know of one who'll do home visits, but that's the exception, and it has to be in an absolute emergency.

Some specific groups of people who seem to miss out in the current service provision system were noted. The same problems facing people whose main language was not English as noted in other places was raised. The particular problems this presented in a smaller place like Canberra were discussed. People with "personality disorders" were often "defined out" of the system although in real need of help. Forensic patients seemed to get only limited and sporadic treatment. It was also noted that people who entered the general health care system who has psychiatric needs often had them overlooked or subsumed (e.g. people who had attempted suicide were often treated for the physical results of the attempt with no referral). Specifically, it was argued that there was no attention to early intervention which might allay some of the pressures on the mental health system caused by crisis intervention.

While it was felt that GPs could play a far greater role in the mental health system, the difficulty in getting some of them interested in the area was mentioned. Further, it was thought that there would need to be some change in their training if they were to have the knowledge and skills that would enable them to play the greater role envisaged.

4. The Common Themes

Overwhelmingly, the groups were quite critical of the current role of psychiatrists in the mental health system. To some degree, this is an artefact of the study method which deliberately focussed attention precisely in that area. And, there was no doubt in consumers' and carers' mind that once one found a good psychiatrist, it was well worth going to great lengths to achieve stability in that relationship. Many of

the very positive comments made in the focus groups related to the particularly good care individuals had experienced from a particularly good practitioner.

Nonetheless, it was quite easy to discern from the focus groups key areas of concern about the practices and training of psychiatrists and the impact of these on the functioning of the private and public mental health service systems.

These concerns are summarised below in order of frequency with which they were reported in the group meetings:

4.1 Continuity of care

Continuity of quality psychiatric care was seen as being of paramount importance to consumers and their carers. The current service system militates against this in two clear ways and these need to be remedied:

- 1. in the private system, the general inability or unwillingness of psychiatrists to maintain contact with their patients when they are admitted to public psychiatric facilities needs to be addressed by systemic change;**
- 2. in the public system, high work loads and the use of the public system for training purposes mean that continuity of care from any individual psychiatrist is almost impossible.** While it was acknowledged that this phenomenon is common in the public system, it would seem most important to address it in this area where the development of a therapeutic relationship of trust is so often essential to the quality of care.

4.2 Access in Emergencies and First Appointments

There were constant reports of long waits to get first or emergency appointments with private psychiatrists and of difficulty getting access to public services in emergency situations. This was often matched by a call for more psychiatrists or services in specific areas. However, the problems encountered seemed to be similar in areas with very different relative numbers of psychiatrists and of public psychiatric services or facilities.

Indeed, it was often remarked that what was needed was not so much “psychiatrists” but better access to skilled diagnosis and appropriate medication, counselling and education about the nature of the illness, its treatment and prospective family and social impacts, and emotional and practical support in the face of the handicaps people with psychiatric illness face in their communities. To the extent that a psychiatrist can provide these services, or work collaboratively in teams that provide these services, more are needed. Simply increasing their supply does not guarantee this.

There appears to be little incentive in the current system for funding private psychiatry to ensure priority for initial and emergency consultations. There seems to be incentive for the practice of establishing a “stable” of “easier” management patients.

The practice of using police to transport people having psychotic episodes to places where they can be sedated pending further treatment emerges, to some extent, from the difficulty in getting people able to give appropriate sedation *in situ*. **There appears to be little incentive in the present system to reward psychiatrists’ involvement other than at their offices** which may relieve some of the most difficult situations the service system presently encounters.

There was almost universal agreement that **there is a need to increase the number of in-patient places available for the treatment of people having psychiatric emergencies.**

Private psychiatric hospitals were not viewed by the bulk of those consulted as being able to make a significant contribution to alleviating current pressures in the system because of the limited number of consumers able to have access to them.

4.3 Greater Access to Counselling

Accounts at the meeting of good care from psychiatrists almost always involved stories of practitioners skilled in communicating with consumers and their carers about the nature and prognosis of their illness, the impacts of

treatment regimes, and in counselling them about the personal emotional problems that often came to light when the crisis in a psychiatric condition subsided.

It was clear from the consultations that consumers and carers felt it was quite serendipitous whether one would find a psychiatrist so skilled. Indeed, it was often reported that these competencies were often better sought elsewhere.

There was general agreement that access to such services needed to be expanded within the mental health system. Options canvassed included:

- **funding these services from psychologists (with reasonable limits on access and extent) under the Medicare rebate arrangements;**
- **making these services readily available in the public system (which is currently viewed as entirely inadequate in this regard);**
- **providing incentives for psychiatrists to work in multi-disciplinary teams or in close liaison with community services where such services are available.**

Consumers and carers also expressed concerns about the nature of psychiatrists’ training from this perspective. Given the length and apparent difficulty of the training program, it was seen as surprising that it generally did not better equip those trained with these skills. The suggestion was made that **moves might be made away from the knowledge and exam based emphasis in training to a practical, skills acquisition approach.**

4.4 Advocacy

The importance of advocacy to enable sometimes vulnerable consumers to obtain quality care was stressed again and again. **The significance of proper funding and resourcing to ensure the provision and quality of advocacy services was continually emphasised.**

It was argued that **mechanisms ought be in place to ensure regular contact between psychiatrists and advocacy groups, and exposure of psychiatrists in training to**

consumers, other than as “patients, would be important steps in emphasising the centrality of advocacy in the service system.

4.5 Training

In addition, there was clear agreement that **training programs and in-service education programs for psychiatrists should have a clear focus on the importance of collaborative work with consumers in addressing the range of “deficits” that occur because of the trauma of psychiatric illness.**

It would also be fair to say that this was seen as a likely remedy and prophylactic for what was often describes as an “attitude problem” among some psychiatrists in regard to consumers, carers and other mental health professionals.

There was a strong belief that there was an over-emphasis on medication in psychiatric treatment. It was clearly recognised that great advances in treatment had come as a result of improvement in medication regimes, but it was felt that some psychiatrists felt that their involvement in treatment ended at this stage, and that **there was lack of professional scrutiny to ensure uniform best practice in diagnosis and pharmaceutical and other treatments.**

4.6 Catch 22 Situations

Several *Catch 22* type situations were identified in the consultation which need effective remedy, the most striking among which were:

- 1. the non-graduated withdrawal of pharmaceutical (and often bulk billing) discounts to psychiatric patients as they return to work;**
- 2. the requirement that consumers who are reluctant to comply with medication regimes pay for medications;**
- 3. the inaccessibility of some Commonwealth support programs such as HACC services, and Disability Support services to people with psychiatric illness.**

4.7 Training and Involvement of GPs

It was suggested that GPs could play a much greater role in the psychiatric service system if given more training in the area.

Indeed, in rural and remote areas, it was felt **that more extensive use of GPs to diagnose and monitor treatment regimes, and the use of resources to fund community mental health workers** was a more realistic, immediate and efficient solution to problems of so called under-supply than proposal to rapidly increase the numbers of psychiatrists. The model proposed certainly envisaged “regional” psychiatrists for specialist oversight, but went far beyond that.

4.8 Prevention and Community Education

It was overwhelmingly clear that consumers and carers felt there had been far too little emphasis generally on community education and preventative supports in the mental health system. Psychiatrists were somewhat singled out in this critique because of the control they have exercised over components of the system for a long time without directing what would be accepted as adequate resources to these areas.

No models were proposed specifically as to how this strategies might be implemented; there was simply quite broad agreement about the need for them.

5. Conclusion

There appeared to be little contention that psychiatrists have played, do and will continue to play an important roles in the mental health service system.

Consumers and carers were quite adamant both explicitly and by implication that they believed the time had come for a broader range of people to have some say in what that role should be.

Overall, the increasing pressures on the public system because of the processes of de-institutionalisation, mainstreaming, and

because of extensive funding constraint, had made its mental health components function less than adequately.

To them, the private system as an alternative seems mixed in quality and less than equitably accessible.

There was a strong feeling that there is always a tendency to believe that a quality mental health service, especially one that involves consumers and carers as advocates and parts of treatment teams, can be provided “on the cheap”.

Appendix 1

Participants in Consultations

Thanks to those who participated in the consultations (and apologies for instances where difficulty reading handwriting has led to incorrect transcription of names):

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